Exhibit B

UnitedHealthcare Options PPO Plan

Active Employees, Partners/Principals

Effective: January 1, 2012

Introduction

The medical benefit options provided under the Deloitte LLP Group Insurance Plan are designed with two important goals in mind. The Plan's primary purpose is to protect you and your family against financial hardship in the event of serious illness or injury. The second goal is to encourage partners/principals, employees, and their families to take an active role in their health care. That involvement begins with selecting one of the medical benefit options offered. Once you have selected the coverage that best meets your health care needs, it is your responsibility to take advantage of the health care alternatives the plan offers. You need to be aware of the operating requirements of the plan so as not to jeopardize receiving the maximum benefits available. This summary represents the UnitedHealthcare Options PPO medical benefit option, herein "the Plan", for eligible partners, principals, and employees of Deloitte LLP and its subsidiaries (the "Deloitte U.S. Firms") effective January 1, 2012.

This summary provides general information about the Plan, who is eligible to receive benefits under the Plan, what those benefits are, and how to obtain benefits. It does not cover all provisions, limitations, and exclusions. No general explanation can adequately give you all the details of the Plan. This general explanation does not change, expand, or otherwise interpret the terms of the Plan. If there is any conflict between the information presented here, or any written or oral communication by an individual representing the Plan, and the Plan document, the terms of the Plan document as interpreted in the sole discretion of the Plan Administrator will govern; determining the rights and benefits to which you will be entitled under the Plan. Deloitte LLP may change, amend, modify, or discontinue the Plan or any part hereof at any time for any reason without prior notice to the extent allowed by applicable law.

This document is neither a contract nor a guarantee of continued employment for any definite period of time. Your employment is always on an at-will basis.

Please read this document carefully. If you have any questions, contact the CallCenter at +1 800 DELOITTE (+1 800 335 6488). You can also submit a request directly to the CallCenter through DeloitteNet.

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Glossary.

As used in this document, "Deloitte" means Deloitte LLP and its subsidiaries. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries. Certain services may not be available to attest clients under the rules and regulations of public accounting.

Who Is Eligible

You are eligible to participate in any one of the sponsored medical Plans if you are a partner/principal or salaried employee of the Deloitte U.S. Firms (or any affiliated firm which has adopted the Plan) regularly scheduled to work 20 or more hours per week. Hourly employees regularly scheduled to work 20 or more hours per week with at least one year of service with the Deloitte U.S. Firms are also eligible to participate.

Those on overseas DTOS long-term assignment will be offered a choice between this Plan and the International Plan.

Interns, cooperative plan students, temporary employees and faculty associates are not eligible. An individual who performs services for the Deloitte U.S. Firms or an affiliated firm pursuant to an agreement (written or oral) that classifies such individual as an independent contractor or as an employee of another entity, or that otherwise contains a waiver of participation in this Plan, regardless of such individual's employment status under common law, is also not eligible to participate.

Partners and principals who are currently on a disability retirement under the Deloitte LLP Memorandum of Agreement shall be eligible to participate in this Plan until such partner or principal attains age 62. After age 62, such partner or principal shall be eligible to participate in Deloitte's retiree medical benefit options only.

Effective April 1, 2011 any partner or principal who begins a disability retirement under the Deloitte LLP Memorandum of Agreement shall not be eligible to participate in this Plan. Such partner or principal shall be eligible to participate in Deloitte's retiree medical benefit options only.

Under the Plan, if you are an eligible participant, you may also cover your dependents. Your eligible dependents include:

- Your spouse
  - Immediate notification of termination of any marriage is required
  - Proof of marriage may be required by the Claims Administrator
  - Your spouse is not your qualified dependent while on active duty in the armed forces of any country
- Your domestic partner (same sex and opposite sex, including common law spouses)
  - The partner/principal or employee must complete a written affidavit required by the Plan or supply a government domestic partner registry that states that they are each other's sole domestic partner and intend to remain so; that neither is currently married or legally separated or in another domestic partnership; that they are least 18 years of age and mentally competent to consent to the affidavit; that they share the same regular and permanent address; that the relationship does not violate the law in the state of residency; that the domestic partner is a citizen of the United States or satisfies residency requirements
  - You can enroll only a spouse or domestic partner under the program. No person will be considered your domestic partner while you have a spouse who is or could be covered as a qualified dependent
  - Immediate notification of termination of any domestic partner relationship is required
  - Your domestic partner is not your qualified dependent while on active duty in the armed forces of any country
- Your children up to age 26
  - Your children include your natural, adopted, and stepchildren, children of a domestic partner, and foster children. In the case of health care expense coverage, your children also include children placed with you for adoption prior to the legal adoption. A child placed with you for adoption prior to legal adoption is considered your qualified dependent from the date of placement for adoption, and is treated as though the child was a newborn child to you
  - Your child is not your qualified dependent while on active duty in the armed forces of any country
  - For the purposes of "When Coverage Ends," a qualified dependent child will not be considered to have attained age 26 until the end of the calendar year during which such child's 26th birthday occurs

- A child will not be considered the qualified dependent of more than one employee at the same time
- Disabled children are eligible dependents if the disability began prior to age 26

Grandfathered adult dependents. To be a grandfathered adult dependent, an adult dependent must have been covered under the Plan prior to January 1, 2011 and must remain covered under the Plan on a continuous basis. If an adult dependent ceases to be covered by the Plan after January 1, 2011, they will no longer be considered a grandfathered adult dependent. A grandfathered adult dependent is one of the following: the adult parents, parents-in-law, or parents of a domestic partner (under age 65) of a partner, principal, or employee. These grandfathered adult dependents must currently live/or plan to live in the same or permanent residence as the partner, principal, or employee and receive over 50% of his or her support from the partner, principal, or employee and qualify as the partner, principal, or employee's dependent for federal income tax purposes

- Not all locally sponsored medical plans have provisions for coverage of adult dependents, and such coverage may not be available from the locally sponsored medical plan available to you
- Immediate notification of termination of adult dependent status is required

No one will be eligible as a dependent while covered as a partner/principal, employee or retiree.

How to Enroll

During your orientation, you will receive instructions about enrolling in the benefit programs. You may elect individual, individual plus spouse/domestic partner, individual plus child(ren), or family medical coverage when you enroll, or you may decline coverage. You must enroll in a plan that is available in the area where you live or work. You will be asked to indicate the members of your family who you want to be covered and they will be covered under the same plan that you elect. Follow all instructions regarding forms or confirmation statements.

If you do not enroll yourself and your eligible dependents in one of the sponsored medical plans within 31 calendar days after you are first eligible, you will have to wait until the next Annual Open Enrollment Period or experience a life event in order to enroll in medical coverage.

This Plan imposes no preexisting condition exclusion. This means that if you have a medical condition before becoming a member of the plan, you will not have to wait a certain period of time before the Plan will provide coverage for that condition. If you have any questions, contact the CallCenter.

Changing Your Benefit Enrollment

Annual Open Enrollment

Each calendar year, an Annual Open Enrollment period is conducted for medical plan enrollment changes effective the first day of the following calendar year.

During Annual Open Enrollment, you may elect to enroll in coverage, change medical plans, or add dependents to your coverage.

You will receive notification of the Annual Open Enrollment period from the CallCenter.

If You Wish to Switch to another Medical Plan

If you are enrolled in a plan and wish to switch to one of the other national or locally sponsored plans offered under the Medical Program, you may do so only at specified times or under certain circumstances:

- Within 31 calendar days of first becoming eligible for coverage
- During the Annual Open Enrollment Period
- Within 31 calendar days of moving out of the Plan service area
- Upon the Plan's ceasing operation

In addition, if you experience a life event, you may be eligible to switch to another plan as follows:

- Within 31 calendar days of a dependent losing eligibility for coverage elsewhere or an employer ceasing contributions to coverage elsewhere, if the employee is adding the dependent to Deloitte coverage
- Within 31 calendar days of gaining a new dependent through marriage, birth, adoption or placement for adoption (see "***Adding New Dependents***")
- If the Deloitte U.S. Firms relocate an employee, thus causing a spouse/domestic partner's employment and medical coverage with another employer to cease, the employee may enroll all eligible family members within 31 calendar days of the transfer to the new location

If both spouses work for and have separate medical coverage with the Deloitte U.S. Firms and either one terminates or leaves service with the Deloitte U.S. Firms, the terminating partner, principal, or employee may be added as a dependent within 31 calendar days of the cancellation of coverage, but the carrier cannot be changed at that time.

In every case, the 31 day enrollment period begins on the date of the event.

The following events will also be considered a change in family status:

- Termination of your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the CallCenter within 60 days of your termination)
- You or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the CallCenter within 60 days of determination of subsidy eligibility). A copy of the annual CHIP notice is available on Deloittenet at https://deloittenet.deloitte.com/CB/Life/ND/Documents/CHIPRA%20Notice.pdf

The above list is not meant to be exhaustive of all life events or all changes you may be able to make. If you experience a life event you may also be able to drop your coverage. For additional detail on what constitutes a life event and what changes are permissible, you should consult the life event grids on Deloittenet at https://deloittenet.deloitte.com/CB/Life/Pages/QualifyingLifeEvents.aspx .

When Coverage Begins

New Enrollments

Your coverage under the Medical Program begins on the first day of the month coinciding with or next following your date of employment (or following one year of service for hourly employees) provided you have enrolled in one of the plans.

Your eligible dependents are covered under the Medical Program when you are, provided you have enrolled your dependents. You must report any additional dependents within 31 calendar days of your eligibility date in order for such dependents to be covered. Forms are available from the CallCenter and on DeloitteNet. The 31 day enrollment period begins on your eligibility date.

Rehires

If you are rehired within six months of, and in the same calendar year as, your termination date and were enrolled in this Plan while active, you do not have to meet the new hire waiting period; your coverage will be reinstated upon date of rehire. However, the reinstatement is not automatic. You must complete the appropriate benefits enrollment. Contact the CallCenter for assistance.

If you were enrolled in this Plan and are rehired within the same calendar year as, but more than six months after, your termination date, you will be automatically reinstated in this coverage as of the first of the month coincident with or next following your date of rehire. However, the reinstatement is not automatic. You must complete the appropriate benefits enrollment.

If you were not covered by this Plan while originally employed, or are rehired in a subsequent calendar year, the rehire provision will not apply and your enrollment will be subject to the new hire enrollment provision.

Adding New Dependents

Employees may enroll dependents that join their family because of any of the following events:

- Birth
- Legal adoption
- Placement for adoption
- Marriage
- Legal guardianship
- Qualified Medical Child Support Order
- Attainment of domestic partner

Coverage for changes resulting from life events is effective on the date of the event if you submit the required documentation within 31 calendar days of the event. You must contact the CallCenter within 31 calendar days of gaining a dependent in order to add the dependent to your coverage. Life Event forms are also available on DeloitteNet. The 31 day enrollment period begins on the date of your life event.

Newborn Child Provision

This provision applies if you are enrolled for coverage when a child is born. You must contact the CallCenter within 31 calendar days of the birth in order to add the child to your coverage under a life event. Notifying the insurance company does not satisfy this requirement; you must contact the CallCenter at +1 800 DELOITTE (+1 800 335 6488) and complete the appropriate paperwork to enroll your newborn child. Life Event forms are also available on DeloitteNet.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is any judgment, decree or order (including approval of a settlement agreement) issued by a court that:

- Provides for child support or health benefit coverage for the child of an eligible participant in a group health plan relating to benefits under the group health plan

- Enforces a law concerning medical child support under a group health plan as provided by state Medicaid laws

A QMCSO is similar to a Qualified Domestic Relations Order (QDRO), except that it applies to group health plan benefits instead of retirement benefits.

If an employee is required by a QMCSO to provide coverage for his/her children, these children can be enrolled as required by law. If the employee is not already enrolled, the employee may also enroll at the same time.

A copy of the Plan's procedures for determining whether a court order is a QMCSO will be provided, free of charge, to participants and beneficiaries upon request to the CallCenter (through DeloitteNet or by calling +1 800 DELOITTE).

Cost of Benefits

Contributions

Rates are updated each calendar year, announced annually, and are provided during the New Hire Orientation. Current rate information is also available on DeloitteNet and from the CallCenter. Rates are available for individual coverage, individual plus a spouse/domestic partner, individual plus child(ren), and family coverage.

Active Employees

You and the Deloitte U.S. Firms share the cost of medical coverage for you and your covered dependents, with the Deloitte U.S. Firms paying a significant percentage of the cost of the premium for you and any eligible dependents. Your contributions for the Medical Program will be made through payroll deductions. Contributions will be made on a before-tax basis, except for domestic partner coverage. This means that your contributions are deducted from your paycheck before taxes are determined. Refer to the Flexible Spending Plan Summary Plan Description, which can be found on DeloitteNet, for additional information.

Active Partners/Principals

You pay the total premium cost on an after-tax basis.

Coinsurance, Copayments and Deductibles

Coinsurance and copayments are determined by the medical plan selected and the service performed.

Identification Cards

A UnitedHealthcare Choice Plus identification (I.D.) card will be issued to you. Your I.D. card includes your group number, copayment information, claims address information, and the UnitedHealthcare Member Services number. For notification of hospital stays or surgery you should call the number on the card prior to the service to receive the highest level of benefits. In emergencies, call UnitedHealthcare Choice Plus Member Services within two working days of your emergency service.

You may obtain I.D. cards by contacting UnitedHealthcare after your enrollment has been sent to UnitedHealthcare. I.D. cards are also available online at www.myuhc.com. Please read the Online Services section for more information.

When you are out of your home service area and need medical care, you can call the number on your card to be directed to the nearest Network physician, or you can perform a provider search at www.myuhc.com or at www.myuhc.com/groups/deloitte2.

Your I.D. card should be carried with you at all times. If your I.D. card is lost or stolen, call UnitedHealthcare Member Services at +1 800 377 2543 or go online to www.myuhc.com.

Please show your new UnitedHealthcare Identification Card to your provider or pharmacy when you receive services.

Overview – How the Plan Works

UnitedHealthcare Choice Plus Plan

What follows is a summary of your benefits, and the copayments and coinsurance applicable to the benefits in the UnitedHealthcare Choice Plus Plan. The choice you make at the time you need medical care will determine your out-of-pocket expenses.

The UnitedHealthcare Choice Plus Plan provides coverage for a wide range of hospital, surgical and other covered medical expenses. It also offers you and your family complete freedom of choice in selecting your health care providers.

Under this Plan, you have the choice of two different medical options to help you meet your health care needs. At any time, you may use a Choice Plus Network provider, and covered expenses will be paid at In-Network levels indicated in the Schedule of Benefits section below. Or, you may use any provider that you choose, even if he or she does not participate in the Network, and receive Out-of-Network benefits for Covered Expenses, as indicated in the Schedule of Benefits. At no time does the UnitedHealthcare Choice Plus require that you obtain a referral to see a provider.

The highlights of the In-Network and Out-of-Network options of the UnitedHealthcare Choice Plus Plan are shown below.

Schedule of Benefits

Refer to the detailed benefit descriptions in this document for additional information.

Benefits Information	In-Network	Out-of-Network
Benefit Period	Calendar Year	Calendar Year
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Maximum	Unlimited	Unlimited
Individual Deductible	None	$200
Family Deductible	None	$600
Individual Out-of-Pocket Maximum	$2,000	$4,000
Family Out-of-Pocket Maximum	$4,000	$8,000
Coinsurance	The Plan pays 90% for most services	The Plan pays 70% for most services
Preventive Care Services		

Benefits Information	In-Network	Out-of-Network
Annual Routine Physical Exams	The Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Well Child / Baby Care (including Immunizations)	The Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Annual Well Woman Exam	The Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Annual Well Man Exam	The Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Routine Eye Screenings	The Plan pays 100% of Covered Expenses ,including refractive examination, every 12 months	The Plan pays 70% of Covered Expenses after deductible
Routine Hearing Screenings	The Plan pays 100% of Covered Expenses (covered as part of routine physical exam only)	The Plan pays 70% of Covered Expenses after deductible
Cancer Screenings		
Mammogram	The Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Prostate	The Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Pap Smear	The Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Colorectal	The Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Physician Office Visits		
Illness and Injury	$20 PCP/$40 specialist copay, then the Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Specialist Visits	$40 copay, then the Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
After Hours / Home Visits	$20 PCP/$40 specialist copay, then the Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Immunizations	The Plan pays 90% of Covered Expenses; 100% for preventive immunizations and those required for business travel	The Plan pays 70% of Covered Expenses after deductible
Surgical Procedure in Physician Office Setting	$20 PCP/$40 specialist, then the Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Allergy Testing and Diagnosis	$40 copay, then the Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Allergy Injections	Injections and serum covered at 100% if in conjunction with an office visit, otherwise injection and serum are covered at 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Maternity Care		
Initial Visit	$20 copay, then the Plan pays	The Plan pays 70% of Covered

Benefits Information	In-Network	Out-of-Network
	100% of Covered Expenses	Expenses after deductible
Subsequent Office Visits	The Plan pays 100% for routine office visits	The Plan pays 70% of Covered Expenses after deductible
Remaining Eligible Expenses	$100 copay for inpatient hospital admission, then the Plan pays 90% of remaining Covered Expenses, including delivery and postnatal care	The Plan pays 70% of Covered Expenses after deductible
Midwife	The Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Outpatient Services		
Outpatient Surgery	$100 copay, then the Plan pays 90% of Covered Expenses for outpatient facility	The Plan pays 70% of Covered Expenses after deductible
Ambulatory Surgical Center Services	$100 copay, then 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Diagnostic Services	Copay is based on the setting where Covered Health Services are rendered	The Plan pays 70% of Covered Expenses after deductible
Outpatient Therapy (Speech, Occupational, Physical)	$20 copay, then the Plan pays 100% of Covered Expenses in physician's office; the Plan pays 90% of Covered Expenses in other facility	The Plan pays 70% of Covered Expenses after deductible
Limits: 30 visits per calendar year per therapy type, combined In-Network and Out-of-Network		
Spinal Manipulations/Chiropractic	$20 copay, then the Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Limits: 30 visits per calendar year, combined In-Network and Out-of-Network		
Inpatient Services		
Hospital Room and Board	$100 copay per admission, then the Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
X-rays and Lab Tests	The Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Maternity Care	$100 copay per admission, then the Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Inpatient Surgery	The Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Anesthesiology	The Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Emergency Care		
Emergency Room	$100 copay (waived if admitted), then the Plan pays 100% of Covered Expenses; not covered if not an emergency	$100 copay (waived if admitted) then the Plan pays 100% of Covered Expenses; not covered if not an emergency
Ambulance	90% of Billed Charges for emergency only	90% of Billed Charges for emergency only
Urgent Care Centers	$40 copay, then the Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible

Benefits Information	In-Network	Out-of-Network
Mental Health Services		
Inpatient	$100 copay per admission, then the Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Outpatient	$20 copay, then the Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Substance Abuse Services		
Inpatient	$100 copay per admission, then the Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Outpatient	$20 copay, then the Plan pays 100% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Prescription Drug Benefits		
Retail (greater of 30 day supply or 100 units)	Generic: 10% coinsurance; minimum: $10 Preferred brand: 20% coinsurance; minimum: $20, maximum: $80 Non-preferred brand: 30% coinsurance; minimum: $40, maximum: $80	Out-of-Network administered through Pharmacy Management; claims must be filed directly with Medco Health Systems
Mail Order (up to a 90 day supply)	Generic: $20 Preferred brand: $40 Non-preferred brand: $80	Not covered
Specialty Drugs	30% coinsurance; minimum: $40, maximum: $80	Not covered
Other Services, Supplies and Facilities		
X-rays and Lab Tests	$20 PCP/$40 specialist copay, then the Plan pays 100% of Covered Expenses; The Plan pays 90% of eligible expenses for services received in an outpatient facility	The Plan pays 70% of Covered Expenses after deductible
Durable Medical Equipment (DME)	The Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Acupuncture	$40 copay, then the Plan pays 100% of Covered Expenses (only covered for nausea and vomiting associated with surgery, chemotherapy and pregnancy)	The Plan pays 70% of Covered Expenses after deductible (only covered for nausea and vomiting associated with surgery, chemotherapy and pregnancy)
Family Planning (Includes Artificial Insemination, IVF, GIFT, ZIFT)	$40 copay, then the Plan pays 100% of Covered Expenses for office visit; the Plan pays 90% of Covered Expenses in other facility. It is recommended that Personal Health Support is contacted	The Plan pays 70% of Covered Expenses after deductible. It is recommended that Personal Health Support is contacted
Limits: $15,000 lifetime maximum, combined In-Network and Out-of-Network		

Benefits Information	In-Network	Out-of-Network
Infertility Drug Coverage	The Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Limits: $7,500 lifetime maximum, combined In-Network and Out-of-Network		
Home Health Care	The Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Limits: 100 visits per calendar year, combined In-Network and Out-of-Network		
Skilled Nursing Facility	$100 copay, then the Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Limits: 120 days per calendar year, combined In-Network and Out-of-Network		
Hospice Facility	The Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible
Limits: 360 days lifetime limit, combined In-Network and Out-of-Network		
Private Duty Nursing	The Plan pays 90% of Covered Expenses • Not covered while confined in a facility • It is recommended that Personal Health Support be contacted prior to first visit	• The Plan pays 70% of Covered Expenses after deductible • Not covered while confined in a facility • It is recommended that Personal Health Support be contacted prior to first visit
All Other Covered Health Expenses for Medical Benefits	The Plan pays 90% of Covered Expenses	The Plan pays 70% of Covered Expenses after deductible

Covered Expenses applied to the Out-of-Network Out-of-Pocket maximum will help satisfy the Network Out-of-Pocket maximum. Covered Expenses applied for the Network Out-of-Pocket maximum will not apply toward the Out-of-Network Out-of-Pocket maximum.

Transplant Benefit Management Program

Benefits for Qualified Procedures performed at a United Resource Network Designated Transplant Facility are payable at 100% of Covered Health Services. Transplants performed at other facilities are payable according to the standard Network and Out-of-Network provisions of the Plan.

Network Benefits

The Claims Administrator or its affiliate arranges for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees or employees of the Claims Administrator. It is your responsibility to select your provider.

The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

You may request a directory of Network providers at no cost to you. Provider directories are always available on myuhc.com. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You are responsible for verifying a provider's Network status prior to receiving services, even when you are referred by another Network provider. You can verify the provider's status or request a provider directory by calling the Claims Administrator.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may

not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get In-Network Benefits.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers agree to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some products. Refer to your provider directory or contact the Claims Administrator for assistance.

The Plan pays 100% of Covered Health Services for preventive care. The Plan pays most other covered medical expenses at 90% with no deductible required when a Choice Plus provider provides the services and supplies. You pay the remaining 10%, which is known as coinsurance. Please note that the percentage is based on Covered Expenses.

Certain types of services require copayments instead of coinsurance. A copayment is the predetermined In-Network charge you pay each time for services such as doctor's office visits and emergency room visits. Once you have paid the copayment for a Covered Health Service, the UnitedHealthcare Choice Plus Plan pays 100% of the remaining covered expenses for that service.

Each person covered under this Plan has an unlimited lifetime maximum for Covered Health Services. You and each of your covered dependents can receive an unlimited amount of benefits for Covered Health Services under the Plan. Refer to What Is Covered for further details.

Out-of-Network Benefits

Out-of-Network Benefits are generally paid at a lower level than In-Network Benefits. Out-of-Network Benefits are payable for Covered Health Services that are provided by Out-of-Network Physicians or Out-of-Network providers. Out-of-Network Benefits are also payable for Covered Health Services that are provided at Out-of-Network facilities.

If you choose to use a provider that is not in the Choice Plus Plan, Covered Expenses will be reimbursed subject to an annual deductible and coinsurance. You must submit claim forms to the insurance company in order to be reimbursed for your expenses. Refer to How to File a Claim for instructions on filing a claim.

After you pay an annual deductible, the Plan pays 70% for most Covered Health Services. Once your expenses total a certain amount, the Plan pays 100% of most Covered Health Service for the remainder of the year. See Out-of-Pocket Feature for more information.

Each year you are responsible for paying the first $200 of Out-of-Network charges covered by the Plan. This is called the Out-of-Network deductible. A separate deductible applies to each covered person. Covered medical expenses for several different causes may be added together to meet the $200 deductible. Charges you incurred in-Network do not count toward this deductible.

If you have elected to cover yourself and one dependent, the Out-of-Network deductible is $400 ($200 for each person).

If you have elected to cover yourself and two or more dependents, there is a family maximum Out-of-Network deductible of $600. Eligible charges incurred by each covered family member may be combined to meet the $600 family deductible amount, but no more than $200 may be applied per person.

Copayments and Deductibles

Before Medical Benefits are payable, each Covered Person must satisfy certain copayments and/or deductibles. A copayment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given. Copayments are not counted toward any deductible or Out-of-Pocket Feature. Covered Health Services that require a copayment are not subject to a deductible.

A deductible is the amount of Covered Expenses the Covered Person must pay before Medical Benefits are payable. After the deductible has been met, Covered Health Benefits are payable at the percentage shown in the Schedule of Benefits.

The amount of each copayment/deductible is shown in the Schedule of Benefits.

Office Visit Copayment

The routine office visit copayment applies to Network Physician's Services. It also applies to Network physical therapist's services if the physical therapist bills for his/her services separately from any other charges.

The Office Visit Copayment applies only to the first prenatal office visit. It does not apply to subsequent routine prenatal and postnatal office visits to the Network obstetrician/gynecologist who is primarily responsible for maternity care.

Individual Deductible

The Out-of-Network Individual Deductible applies to Covered Expenses charged by an Out-of-Network Provider. It applies each calendar year.

Family Deductible

The most a family will have to pay for Out-of-Network Individual Deductibles in any calendar year, no matter how large a family may be, is the amount of the Out-of-Network Family Deductible. No individual will be responsible for more than the Individual Deductible. Only Covered Expenses that count toward the Covered Person's Out-of-Network Individual Deductible count toward this deductible.

Out-of-Pocket Feature

Covered Expenses are payable at the percentage shown in the Schedule of Benefits until any Out-of-Pocket Maximum shown in the Schedule of Benefits has been reached during a calendar year. Then, Covered Expenses are payable at 100% for the rest of that year.

Out-of-Pocket Maximum

Individual Out-of-Pocket Maximum

When the In-Network Individual Out-of-Pocket Maximum is reached for any one Covered Person in a calendar year, In-Network Covered Expenses are payable at 100% for that covered individual for the rest of that year.

When the Out-of-Network Individual Out-of-Pocket Maximum is reached for any one Covered Person in a calendar year, Out-of-Network Covered Expenses are payable at 100% for that person for the rest of that year.

Family Out-of-Pocket Maximum

When the In-Network Family Out-of-Pocket Maximum is reached for all Covered Family Members in a calendar year, In-Network Covered Expenses are payable at 100% for all Covered Family Members for the rest of that year.

When the Out-of-Network Family Out-of-Pocket Maximum is reached for all Covered Family Members in a calendar year, Out-of-Network Covered Expenses are payable at 100% for all Covered Family Members for the rest of that year.

Personal Health Support

Personal Health Support is designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this SPD, the Personal Health Support program includes:

- Admission counseling - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.

- Inpatient care management - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.

- Readmission Management - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- Risk Management - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

Network providers are generally responsible for notifying Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying Personal Health Support.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying Personal Health Support before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if Personal Health Support is not notified.

The services that require Personal Health Support notification are:

- ambulance – non-emergent air and ground
- Congenital Heart Disease services
- dental services - accident only
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes
- home health care
- hospice care - inpatient
- Hospital Inpatient Stay, including Emergency admission
- infertility services
- maternity care that exceeds the delivery timeframes as described in the Additional Coverage Details section
- obesity surgery
- outpatient dialysis treatments as described in under Therapeutic Treatments - Outpatient in the Additional Coverage Details section
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services
- transplantation services

Special Note Regarding Mental Health and Substance Abuse Services

You must provide pre-service notification as described below. You are not required to provide pre-service notification when you seek these services from Network providers. In-Network providers are responsible for notifying the Mental Health/Substance Abuse Administrator before they provide these services to you.

When Benefits are provided for any of the services listed below at an Out-of-Network provider, the following services require notification:

- Mental Health Services – inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility): intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.

- Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.
- Substance Abuse Services – inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program

treatment; outpatient electro-convulsive treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.

For a scheduled admission, you must notify the Mental Health/Substance Abuse Administrator prior to the admission, or as soon as reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. Services requiring prior notification are:

- intensive outpatient program treatment;
- outpatient electro-convulsive treatment;
- psychological testing; and
- extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify the following before receiving Covered Health Services:

1. Care Coordination
2. Personal Care Support, or
3. Personal Health Support

Since Medicare pays benefits first, the Plan will pay Benefits second as described in the section titled Coordination of Benefits.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Emergency Care

When Emergency Care is required which results in a confinement, the Covered Person (or that person's representative or Physician) should call Personal Health Support within two working days of the date the confinement begins. A working day is a business day. It does not include Saturday, Sunday or a State or Federal holiday. If it is not reasonably possible to call Personal Health Support within two working days, Personal Health Support should be notified as soon as reasonably possible

When the Emergency Care has ended, however, Personal Health Support should be called before any additional services are received.

Designated United Resource Network Facilities and Other Providers

If you have a medical condition that Personal Health Support believes needs special services, they may direct you to a Designated United Resource Network Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health Support may direct you to an Out-of-Network facility or provider.

What Is Covered

This Plan pays for Covered Health Services received from either In-Network or Out-of-Network Providers. If In-Network Providers are used, this Plan pays a greater portion of Covered Expenses. This is called the In-Network level. If Out-of-Network Providers are used, this Plan pays a lesser portion of Covered Expenses. This is called the Out-of-Network level.

A directory of the Network Providers is available online at www.myuhc.com/groups/deloitte2, or you can contact the CallCenter at +1 800 DELOITTE (+1 800 335 6488) for assistance in locating a provider. If you are traveling and would like to locate a Network provider, call the number on your I.D. card (+1 800 377 2543).

There are many types of providers who participate in the Network. The following types of providers typically participate in the Network:

- Ambulatory Surgical Centers
- Chiropractors
- Durable Medical Equipment Providers
- Home Health Care Providers
- Home IV Providers
- Hospices
- Hospitals
- Physical Therapists
- Physicians
- Podiatrists
- Rehabilitation Facilities
- Skilled Nursing Facilities
-

Covered Expenses

Covered Expenses are the amount that the Claims Administrator will pay for Benefits, as determined by us or by our designee. In almost all cases our designee is UnitedHealthcare. We have delegated to UnitedHealthcare the discretion and authority to initially determine on our behalf whether a treatment or supply is a Covered Health Service and how the Covered Expense will be determined and otherwise covered under the Plan.

When you receive Covered Health Services from Network providers, you are not responsible for any difference between the Covered Expenses and the amount the provider bills, unless you agreed to reimburse the provider for such services. For Out-of-Network Benefits, except for fees that are negotiated by an Out-of-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, you are responsible for paying, directly to the Out-of-Network provider:

- the deductible,
- any difference between the amount the provider bills you and the amount we will pay for Covered Expenses, and
- any amounts in excess of any Plan maximum.

Out-of-Network Providers Paid at the In-Network Level

Emergency Care is payable at the In-Network level (paid the same whether you are in or out of the Network), even if services are received from an Out-of-Network Provider. That means that if you seek Emergency care at an Out-of-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Covered Expenses and the amount the provider bills.

Network Provider Charges Not Covered

A Network Provider has contracted with UnitedHealthcare to participate in the Network. Under this contract, a Network Provider may not charge the Covered Person or UnitedHealthcare for certain expenses, except as stated below. A Network Provider cannot charge the Covered Person or UnitedHealthcare for any services or supplies which are not necessary.

The Covered Person may agree with the Network Provider to pay any charges for services and supplies which are not necessary. In this case, the Network Provider may make charges to the Covered Person. However, these charges are not Covered Expenses under this Plan and are not payable by the Claims Administrator.

Medical Benefits

Medical Benefits are payable for Covered Expenses incurred by the Covered Person while covered under this Plan.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Plan is in effect
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in When Coverage Ends occurs
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan

Each Covered Person must satisfy certain copayments and/or deductibles before any payment is made for certain Covered Health Services. Then Medical Benefits pays the percentage of Covered Expenses shown in the Schedule of Benefits.

Covered Health Services

Covered Health Services must be necessary and given for the diagnosis or treatment of an accidental injury or Sickness.

A Covered Person and his or her Physician decide which services and supplies are given; this Plan pays for the following Covered Health Services which are necessary as determined by the Claims Administrator.

Covered Health Services also include services and supplies that are part of an Alternate Care Proposal (ACP). An ACP is a course of treatment developed by UnitedHealthcare and authorized by the Employer as an alternative to the services and supplies that would otherwise have been considered Covered Health Services.

Unless the ACP specifies otherwise, the provisions of the Plan related to benefit amounts, maximum amounts, copayments and deductibles will apply to these services.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or

- Acupuncturist.
-

Covered Health Services include treatment of nausea as a result of:

Chemotherapy;
Pregnancy; and
Post-operative procedures.

Allergy Treatment

Diagnosis, injections and allergy testing are covered.

Ambulatory Surgical Center Services

A Center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

Anesthetics

Covered at standard In-Network and Out-of-Network levels. In emergency situations where a member uses In-Network facilities and providers, but is given an Out-of-Network anesthesiologist, the Plan applies coinsurance against billed charges rather than against Covered Expenses.

Cancer Resource Services

Personal Health Support will arrange for access to certain of its Network Providers participating in the Cancer Resource Services Program for the provision of oncology services. The oncology services include Covered Health Services rendered for the treatment of a condition that has a primary or suspected diagnosis relating to oncology.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www.urncrs.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury
- Physician Fees for Surgical and Medical Services
- Scopic Procedures - Outpatient Diagnostic and Therapeutic
- Therapeutic Treatments - Outpatient
- Hospital - Inpatient Stay
- Surgery - Outpatient

Note: The services described under Travel and Lodging are Covered Health Services only in connection with cancer-related services received at a Designated Facility, or as they apply for transplant procedures or the Congenital Heart Disease program.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper

notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Chemotherapy

Covered as a medical expense.

Cochlear Implant

Cochlear implant is a covered health service for adults and children (ages consistent with U.S. Food and Drug Administration (FDA) indications), for the following diagnoses:

- Severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination, or
- Post-lingual sensorineural deafness in adults.

Congenital Heart Disease Program

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing
- evaluation
- surgical interventions
- interventional cardiac catheterizations (insertion of a tubular device in the heart)
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology)
- approved fetal interventions

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury
- Physician Fees for Surgical and Medical Services
- Scopic Procedures - Outpatient Diagnostic and Therapeutic
- Therapeutic Treatments - Outpatient
- Hospital - Inpatient Stay
- Surgery - Outpatient

Note: The services described under Transportation and Lodging are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program, transplant procedures or Cancer Resource Services.

Transportation and Lodging in Connection with CHD Services

Personal Health Support will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up
- Covered Expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate

There is a $10,000 combined maximum per episode of care per Covered Person for all transportation and lodging expenses incurred by the patient and companion(s) that is reimbursed under this Plan in connection with CHD services received at a Congenital Heart Disease Resource Services program, transplant procedures or Cancer Resource Services.

Dialysis

Benefits are payable subject to In-Network and Out-of-Network provisions.

Durable Medical Equipment

Durable Medical Equipment means equipment which meets all of the following:

- It is for repeated use and is not a consumable or disposable item
- It is used primarily for a medical purpose
- It is appropriate for use in the home
- It is consistent with the patient's bodily function needs

Some examples of Durable Medical Equipment are:

- Appliances which replace a lost body organ or part or help an impaired one to work
- Orthotic devices such as arm, leg, neck, and back braces
- Hospital-type beds
- Equipment needed to increase mobility, such as a wheelchair
- Respirators or other equipment for the use of oxygen
- Monitoring devices
- Braces that stabilize an injured body part and braces to treat curvature of the spine
- Orthotic appliances and devices only when both of the following conditions are met:
- They are prescribed by a Physician for a medical purpose
- They are custom manufactured or custom fitted to an individual Covered Person

Examples of excluded orthotic appliances and devices include but are not limited to: foot orthotics, cranial bands, or any braces that can be obtained without a Physician's order. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

Benefits also include speech aid devices and trachea-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

The Claims Administrator decides whether to cover the purchase or rental of the equipment.

At the Claim Administrator's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the

Covered Person's medical condition occurs sooner than the three-year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at anytime and are not subject to the three year timeline for replacement.

Emergency Care

Emergency Room

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment. Urgent Care services can be obtained from an In-Network or Out-of-Network Provider. If you experience an accidental injury or a medical problem, the Claims Administrator, on behalf of the Deloitte U.S. Firms, will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an Emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an Emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

Family Planning

Family Planning Benefits

Benefits are payable for Covered Expenses for Family Planning Benefits incurred by the Covered Person while covered under this Plan.

Covered Expenses are the actual cost to the Covered Person for the Covered Health Services listed in this Benefit. A Covered Expense is incurred on the date that the Covered Health Service or Supply is performed or given.

These Family Planning Benefits are subject to the same copayments, deductibles and percentage of Covered Expenses payable as benefits that are paid due to Sickness under Medical Benefits.

After coverage under this Plan stops, there are no extended benefits.

Covered Health Services

Contraceptive drugs, services and devices, including but not limited to:

- Intrauterine device and related Physician services
- Diaphragm and related Physician services
- Depo-Provera
- Voluntary sterilization by either vasectomy or tubal ligation

Charges for oral contraceptives are covered as described under Prescription Drug Benefits section of this Summary Plan Description.

Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.

Infertility

The Plan pays for Covered Health Services for infertility services and associated expenses for the diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician.

To be eligible for infertility Benefits, the Covered Person must:

- have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35;
- be under age 44, if female; and
- have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.
-

Diagnosis and treatment of infertility is covered as follows:

- Covered Health Services for diagnosing infertility in female patients:
- Cultures (cervical, vaginal, uterine)
- Endometrial biopsy, dilation and curettage
- Hormone Asay (LH, FSH, Progesterone, Prolactin, Estradiol, Thyroid)
- Hysterosalpingogram
- Hysteroscopy
- Laparoscopy
- Pelvic ultrasound

Covered Health Services for diagnosing infertility in male patients:

- Culture (genital)
- Hormone Assay (LH, FSH, Prolactin, Testosterone)
- Rectal Ultrasound
- Semen Analysis
- Sperm antibodies (semen only)
- Testicular Biopsy
- Vasography

Covered Health Services for infertility services and associated expenses including:

- Diagnosis and treatment of infertility when provided by or under the direction of a physician
- In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment
- Embryo transport
- When a required course of treatment is demonstrated to cause infertility, embryo cryopreservation is a covered expense
- Donor ovum and semen and related costs, including collection and preparation
- Artificial insemination
- Microinjection techniques.

There is a $15,000 lifetime maximum applicable to infertility services. Infertility prescriptions are subject to a separate $7,500 lifetime maximum.

Reproductive Resource Services

You are also eligible to participate in a program called Reproductive Resource Services (RRS), which is designed to assist employees and dependents that are enrolled in the UnitedHealthcare (UHC) Medical Plans and are in need of *infertility* services. This program is available at no additional charge.

The RRS program provides a **specialized network** of infertility treatment programs, nurse-consulting services, and educational tools to support safe and effective care for employees, dependents and their future babies. The RRS mission is to help get you the right care, at the right place, at the right time.

Through this program, RRS can help employees and dependents work through questions relating to their specific medical circumstances and available treatment options. Licensed nurses, specializing in infertility, at RRS can answer questions such as:

- When should I seek infertility treatment?
- Where is the best place to be treated for infertility?
- What treatments and options are available to me?

If you are interested in accessing RRS services or getting more information please call +1 866 774 4626 or visit their website at http://www.urnrrs.com. The web site provides educational information regarding infertility treatment, resources, providers and FAQs.

For Infertility services, the Plan pays Benefits as described under:

- Office Visits
- Office Visits for Specialists
- Physician Services
- Inpatient Care
- Outpatient Surgery, Diagnostic and Therapeutic Services.

Foot Care

Care and treatment of the feet, if needed due to severe systemic disease. Routine care such as removal of warts, corns, or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches, and chronic foot strain is a Covered Health Service only if needed due to severe systemic disease.

Treatment of metatarsalgia or bunions is not covered except for charges for open cutting procedures. The removal of nail roots and services done in connection with the treatment of metabolic or peripheral-vascular diseases are considered Covered Health Services.

Treatment of subluxation (joint or bone dislocation) of the foot are not covered including shoes (standard or custom), lifts and wedges, and shoe Orthotics that are not prescribed by a Physician.

Hearing Care

Benefits are available for the following Covered Health Services when received from a provider in the provider's office:

- Routine hearing exams, covered annually at 100% as part of routine physical exam
- Hearing exams in case of Injury or Sickness
- Hearing aids which are required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness)

Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing. Benefits are limited to two (2) hearing aids per person, per lifetime.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of wearable hearing aid; or
- Hearing loss of sufficient severity that would not be adequately remedied by a wearable hearing aid.

Home Health Care

The following Covered Health Services must be given by a Home Health Care Agency:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.)
- Temporary or part-time care by a home health aide
- Physical therapy
- Occupational therapy
- Speech therapy

Covered Health Services are limited to 100 visits each calendar year, combined In-Network and Out-of-Network. Each period of home health aide care of up to four hours given in the same day counts as one visit. Each visit by any other member of the home health team will count as one visit.

Personal Health Support will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social and spiritual care for the terminally ill person, and

short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency.

Any combination of In-Network and Out-of-Network Benefits is limited to 360 days during each Covered Person's lifetime.

Hospital Services

- Room and Board
- Covered Expenses for a private room are limited to the regular daily charge made by the Hospital for a semi-private room, unless a private room is necessary
- Other Services and Supplies
- Emergency Room
- Services and supplies received during the inpatient stay; with room and board in a semi-private room (a room with two or more beds)

Laboratory Tests and X-rays

Non-preventive X-rays or tests for diagnosis or treatment are covered according to the schedule of benefits. Preventive X-rays or tests are covered at 100%.

Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure
- Blood or blood derivatives only if not donated or replaced.

Medical Transportation Services

Transportation by professional ambulance, other than air ambulance, to and from a medical facility is covered at 90% coinsurance, both In-Network and Out-of-Network. For initial transport to a hospital, emergency ambulance services must be necessary.

Transportation by regularly scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment is covered. Condition must meet the definition of an emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, the Claims Administrator may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits include the following services provided on either an outpatient or inpatient basis:

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.
- Benefits include the following services on an outpatient basis:
- Intensive Outpatient Treatment.

The Mental Health/Substance Abuse Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. You are encouraged to contact the Mental Health/Substance Abuse Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Abuse Administrator may become available to you as part of your Mental Health Services benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Abuse Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others or property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following services provided on either an outpatient or inpatient basis:

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provided-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Abuse Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. You are encouraged to contact the Mental Health/Substance Abuse Administrator for referrals to providers and coordination of care.

Substance Abuse Services

Substance Abuse Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention; and
- detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Abuse Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. You are encouraged to contact the Mental Health/Substance Abuse Administrator for referrals to providers and coordination of care.

Special Substance Abuse Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Abuse Administrator may become available to you as part of your Substance Abuse Services benefit. The Substance Abuse Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance Abuse which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Abuse Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

It is recommended that you contact United Behavioral Health at 1 (800) 337-2543 one business day prior to receiving Mental Health/Substance Abuse services; however you are not required to notify the plan to receive Covered Health Services. In-Network providers are responsible for notifying the Mental Health/Substance Abuse Administrator before they provide these services to you.

Special Note Regarding Mental Health and Substance Abuse Services

You must provide pre-service notification as described below. You are not required to provide pre-service notification when you seek these services from Network providers. In-Network providers are responsible for notifying the Mental Health/Substance Abuse Administrator before they provide these services to you.

When Benefits are provided for any of the services listed below at an Out-of-Network provider, the following services require notification:

- Mental Health Services – inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility): intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.
- Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.
- Substance Abuse Services – inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.

For a scheduled admission, you must notify the Mental Health/Substance Abuse Administrator prior to the admission, or as soon as reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. Services requiring prior notification are:

- intensive outpatient program treatment;
- outpatient electro-convulsive treatment;
- psychological testing; and
- extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.

Nurse Practitioner Services

Services of a licensed or certified Nurse Practitioner acting within the scope of that license or certification.

Oral Surgery and Dental Services

The following services are covered by the Plan:

- Dental transplant preparation

- Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system)
- Direct treatment of cancer or cleft palate.

Before the Plan will cover treatment of an injured tooth, the dentist must certify that the tooth is virgin or unrestored, and that it:

- Has no decay
- Has no filling on more than two surfaces
- Has no gum disease associated with bone loss
- Has no root canal therapy
- Is not a dental implant
- Functions normally in chewing and speech

Dental services shown above are covered by the Plan when all of the following are true:

Treatment is necessary because of accidental damage to a sound, natural tooth
Dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth
Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry
The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident

Dental services for final treatment to repair the damage must be started within three months of the accident and completed within 12 months of the accident.

Orthognathic Surgery Benefits:

Upper and lower jawbone surgery as required for:

- Direct trauma of acute traumatic injury or cancer
- Jaw alignment and treatment for the temporamandibular joint, and treatment for obstructive sleep apnea
- A jaw deformity resulting from facial trauma or cancer
- A skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following:
- Inability to incise solid foods
- Choking on incompletely masticated solid foods
- Damage to soft tissue during mastication
- Speech impediment determined to be due to the jaw deformity
- Malnutrition and weight loss due to inadequate intake secondary to the jaw deformity

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections. Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include U.S. Food and Drug Administration (FDA)-approved TMJ implants only when all other treatment has failed.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under Hospital – Inpatient Stay and Physician Fees for Surgical and Medical Services, respectively.

Dental Services - Anesthesia and Hospitalization only

Anesthesia and Hospitalization Benefits for dental services include Covered Health Services provided in a Hospital or Alternate Facility for dental conditions likely to result in a medical condition if left untreated, if the service:

- Is determined by a Physician to require dental treatment in a Hospital or Alternate Facility, due to a complex dental condition or a developmental disability that prevents effective treatment in a dental office; or
- Has one or more medical conditions that would create undue medical risk if dental treatment were provided in a dental office.

Organ/Tissue Transplants

Personal Health Support must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation
- The donor search
- The organ procurement/tissue harvest
- The transplant procedure

Services and supplies for necessary organ or tissue transplants are payable under this Plan. The maximum for travel and lodging is $10,000 per episode of care. Organ search and procurement charges are payable to the medical plan maximum, which is unlimited. Bone marrow search and procurement are payable to the medical plan maximum, which is unlimited.

Donor Charges for Organ/Tissue Transplants

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- Heart
- Heart/Lung
- Lung
- Kidney
- Kidney/Pancreas
- Liver
- Liver/Kidney
- Liver/Intestinal
- Pancreas

- Intestinal
- Bone Marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.

Medical Care and Treatment

The Covered Expenses for services provided in connection with the transplant procedure include:

- Pre-transplant evaluation for one of the procedures listed above
- Organ acquisition and procurement
- Hospital and physician fees
- Transplant procedures
- Follow-up care for a period up to one year after the transplant
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. Bone marrow search and procurement are payable to the medical plan maximum, which is unlimited.

Transportation and Lodging

Personal Health Support will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the transplant recipient, or receiving cancer-related treatment associated with the Cancer Resource Services program and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site where services are given for the purposes of an evaluation, the procedure or other treatment, or necessary post-discharge follow-up
- Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging expense will be reimbursed up to the $100 per diem rate

There is a $10,000 combined maximum per episode of care per Covered Person for all transportation and lodging expenses incurred by the patient and companion(s) that is reimbursed under this Plan in connection with CHD services received at a Congenital Heart Disease Resource Services program, transplant procedures or Cancer Resource Services.

Orthoptic Training (Eye Muscle Exercise)

Covered Health Services include training by a licensed optometrist or an orthoptic technician.

Outpatient Occupational Therapy

Services of a licensed occupational therapist provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan

Covered Health Services are limited to 30 visits per calendar year (In-Network and Out-of-Network combined). Additional visits may be available if necessary.

Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Outpatient Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan

Covered Health Services are limited to 30 visits each calendar year. Additional visits may be available if necessary. Covered Health Services are limited to three types of treatment to each body part during each visit (In-Network and Out-of-Network combined).

Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Outpatient Surgery, Diagnostic and Therapeutic Services

Covered Health Services received on an outpatient basis at a hospital or alternate facility including surgery and related services, lab and radiology/X-ray, mammography testing and other diagnostic tests and therapeutic treatments including cancer chemotherapy or intravenous infusion therapy.

Outpatient Surgery/Facility

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Benefits under this section include:

- The facility charge and the charge for supplies and equipment; and
- Certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy).

Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services - Sickness and Injury in this section.

Physician Services

- Medical Care and Treatment
- Hospital, office and home visits
- Emergency room services

Pregnancy Benefits

Benefits are payable for Covered Health Services for pregnancy given to the Covered Person while covered under this Plan. These Covered Health Services are listed in Medical Benefits. Benefits for pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery
- 96 hours of inpatient care for the mother and newborn child following a cesarean section

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

After coverage under this Plan stops, extended benefits for pregnancy are the same as for Sickness.

The Office Visit Copayment does not apply to prenatal and postnatal office visits (after the initial diagnosis) by the Network obstetrician/gynecologist who is primarily responsible for the patient's maternity care.

Additional Covered Health Services specific to pregnancy are listed below. These Additional Covered Health Services are subject to the same requirements as Covered Health Services listed in Medical Benefits.

Healthy Pregnancy Program

If you are pregnant and enrolled in this medical plan, you can get valuable educational information and advice by calling the toll-free number on your I.D. card. This program offers maternity nurses on duty 24 hours a day; a free copy of The Healthy Pregnancy Guide; a phone call from a maternity nurse halfway through your pregnancy to see how things are going; a phone call from a nurse approximately four weeks post partum to give you information on infant care, feeding, nutrition, immunizations and more; and a copy of a publication that focuses on the first two years of life. Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of pregnancy. You can enroll at any time up to your 34th week. To enroll, call the toll-free number on your I.D. card.

Birth Center Services

- Room and Board
- Other Services and Supplies
- Anesthetics

Birthing centers are typically Out-of-Network. However, if a birthing center is attached to a Network hospital, the services will be considered for payment at 90% coinsurance. Otherwise, Birth Center Services will be covered at 70% coinsurance after deductible.

Nurse-Midwife's Services

Services of a licensed or certified Nurse-Midwife will be covered at 90% In-Network and 70% after deductible for Out-of-Network service.

Routine Well Baby Care

The following services and supplies given during a newborn child's initial Hospital confinement:

- Hospital services for nursery care
- Other Services and Supplies given by the Hospital
- Services of a surgeon for circumcision

- Physician Services

Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.

Neonatal Resource Services

Neonatal Resource Services (NRS) works in conjunction with UnitedHealthcare's Healthy Pregnancy Program to identify pregnancies that may be at high risk and encourages delivery at neonatal intensive care unit (NICU) services provided by a **specialized network** of facilities participating in the Neonatal Resource Services (NRS) program.

If you have been identified during pregnancy of being at risk for preterm birth, NRS nurses will consult with you to help you make informed decisions about your delivery options and care. Upon delivery, the NRS nurse will continue to monitor your baby's NICU stay and to answer questions about your health and the health of your baby.

If you are interested in accessing NRS or you have questions about the program, you or your covered Dependent may call +1 888 936 7246.

For neonatal intensive care, the Plan pays Benefits as described under:

- Office visits
- Office visits for Specialists
- Physician Services
- Inpatient care
- Outpatient Surgery, Diagnostic and Therapeutic Services.

Prescribed Drugs and Medicines

Outpatient prescription drug benefits are payable as described in the Schedule of Benefits in this document.

Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier 1, tier 2 and tier 3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, you can visit myuhc.com or call the toll-free number on your I.D. card for the most current information.

Each tier is assigned a copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your copay will also depend on whether or not you visit the pharmacy or use the mail order service. The tier system works as follows:

- Tier 1 is your lowest copay option. For the lowest out-of-pocket expense, you should consider tier 1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier 2 is your middle copay option. Consider a tier 2 drug if no tier 1 drug is available to treat your condition.
- Tier 3 is your highest copay option. The drugs in tier 3 are usually more costly. Sometimes there are alternatives available in tier 1 or tier 2.

For Prescription Drugs from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable copay and/or Coinsurance; or
- The Prescription Drug cost for that particular Prescription Drug.

Generic drugs may be substituted for brand-name products where permitted by law. If a member elects to receive a brand name prescription when a generic prescription is available, the member will be responsible for the coinsurance/copay plus the difference in the cost between the generic and brand name medications. Members whose doctors include on their prescriptions 'DAW' or dispense as written will receive the brand name medication at the brand name copay and will not be responsible for the cost differential.

If the actual cost of the prescription is less than the applicable coinsurance/copay, you will pay the actual cost of the drug.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting the Claims Administrator.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the copay. The Plan pays Benefits for certain covered Prescription Drugs:

- As written by a Physician
- Up to a consecutive 31 day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits
- When a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31 day supply, the copay that applies will reflect the number of days dispensed
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay copay for each cycle supplied.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for experimental or investigational, or unproven services unless you meet the specific requirements under the Experimental and Investigational Treatment section. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90 day supply of a covered maintenance drug through the mail. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can contact the Claims Administrator.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and
- up to a consecutive 90 day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

These supply limits do not apply to Specialty Prescription Drugs, including Specialty Prescription Drugs on the List of Preventive Medications. Specialty Prescription Drugs from a mail order Network Pharmacy are subject to the supply limits stated above under the heading Specialty Prescription Drugs.

You may be required to fill an initial Prescription Drug order and obtain refills through a retail pharmacy prior to using a mail order Network Pharmacy.

Prescription Drug Benefits

Prescription Drug Benefits are payable as described in the Schedule of Benefits in this document.

Covered Health Expenses

The Plan covers expenses incurred by you or covered family members for prescription drugs dispensed by a licensed pharmacist upon a physician's written prescription order. The following drugs are covered under the Plan:

- Legend drugs, i.e., drugs that are required to carry the legend "CAUTION: Federal law Prohibits Dispensing without a Prescription," except excluded agents indicated in this document
- Insulin by prescription
- Disposable insulin needles and syringes up to a 90-day supply or 100 units, whichever is greater
- Disposable blood, urine, glucose, and acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips, and Tes-Tape)
- Legend prescription oral contraceptives. Oral contraceptives may be obtained in a quantity to represent three cycles or a 90-day therapy, provided that three copayments are paid at the time the prescription is filled
- Legend smoking cessation products if a prescription is required
- Compounded medication containing at least one ingredient that is a prescription legend drug

Any other drug that under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber

Expenses that Are Not Covered

The Plan will not pay for the following:

- Charges for administering or injecting any drug
- Non-legend drugs other than those listed under Covered Expenses

- Drugs not approved by the Federal Food and Drug Administration (FDA)
- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed on preceding pages
- Medications sold over-the-counter, with no prescription required
- Prescriptions that an eligible person is entitled to receive without charge under any Workers' Compensation laws
- Infertility drugs
- Drugs labeled "Caution - limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual
- Vitamins; other than those vitamins that are determined by the United Pharmacy and Therapeutics Committee to have a specific clinical treatment value. Contact UnitedHealthcare for additional information about covered vitamins
- Unit dose medications
- Immunization agents, biological sera, blood, or blood plasma
- Growth hormones unless pre-approved
- Levonorgestrel (Norplant)
- Minoxidil (Rogaine) for treatment of alopecia
- Tretinoin (Retin A), all dosage forms for individuals 26 years of age or older unless prior authorization is obtained
- Medication taken during a period of confinement in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution that has a facility for dispensing drugs
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order
- Any drug, unless dispensed by a licensed pharmacist upon a physician's written prescription order
- Any medication for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received
- Any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law
- Pharmaceutical Products for which Benefits are provided in the medical (not in the Prescription Drugs section) portion of the Plan. This exclusion does not apply to immunizations administered in a Network or non-Network Pharmacy
- Any medication available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier 3 dispensed outside of the United States, except in an Emergency)
- Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered)

- for smoking cessation
- growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition)
- the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
- new drugs and/or new dosages, until they are reviewed and assigned to a category by the PDL Management Committee
- new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee
- oral non-sedating antihistamines or a combination of antihistamines and decongestants
- Any medication prescribed, dispensed or intended for use during an Inpatient Stay
- Any medication prescribed for appetite suppression, and other weight loss products
- Any medication prescribed to treat infertility
- Prescription Drugs, including new Prescription Drugs or new dosage forms, that Deloitte determines do not meet the definition of a Covered Health Service
- Prescription Drugs when prescribed as sleep aids
- Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug
- Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug
- Any medication typically administered by a qualified provider or licensed health professional in an outpatient setting (This exclusion applies to Depo-Provera and other injectable drugs used for contraception)
- Diaphragms
- Unit dose packaging of Prescription Drugs
- Any medication used for conditions and/or at dosages determined to be experimental or investigational, or unproven, unless The Claims Administrator and Deloitte have agreed to cover an experimental or investigational or unproven treatment
- Any medication used for cosmetic purposes
- Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed
- vitamins, except for the following which require a prescription:
    - prenatal vitamins
    - vitamins with fluoride
    - single entity vitamins

Other exclusions that apply to this benefit are in General Exclusions and Limitations.

Preventive Health Care Benefits

Preventive care is an important and valuable part of your healthcare. Regular physical check-ups and appropriate screenings can help you and your doctor detect illness early. When you treat an illness or condition early, you minimize the risk of a serious health problem and reduce the risk of incurring greater costs. Your Plan provides many preventive care services for free or only a small copayment when you use network providers. No benefits are available when you use an out-of-network provider.

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Preventive Care services include Outpatient services and Office services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

In general, the Plan pays preventive care Benefits based on services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF). The Plan will pay Benefits for Covered Health Services listed below, as well as preventive care services for which your Physician documents the need based on your family or medical history. If the USPSTF's recommendations change, your preventive care Benefits may also change.

Preventive health care services are payable at 100% of the Maximum Allowed Amount and are not subject to deductible.

PREVENTIVE CARE BENEFITS

ANNUAL PHYSICAL EXAM
- One per calendar year

DIAGNOSTIC SCREENING TESTS
- Cholesterol: 1 every 2 years (except for triglyceride testing)
- Diabetes (if pregnant or considering pregnancy)
- Colorectal cancer
  - Fecal occult blood test if age 40 or over: 1 per year
  - Sigmoidoscopy if age 40 or over: 1 every 2 years
- Routine Prostate Specific Antigen (PSA) in asymptomatic males
  - Over age 50-: 1 every year
  - Between ages 40-49 if risk factors exist: 1 per year
  - If prior history of prostate cancer, PSA at any age
- Diagnostic PSA: 1 per year

WELL-WOMAN CARE
- Office visits
- Pap smears
- Bone Density testing and treatment
  - Ages 52 through 65 - 1 baseline
  - Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis)
  - under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)*
- Mammogram (based on age and medical history)
  - Ages 35 through 39 – 1 baseline
  - Age 40 and older – 1 per year

WELL-CHILD CARE (covered services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics)

- In-hospital visits
  - Newborn: 2 in-hospital exams at birth following vaginal delivery
  - Newborn: 4 in-hospital exams at birth following c-section delivery
- Office visits
  - From birth up 1st birthday: 7 visits
  - Ages 1 through 4 years of age: 7 visits
  - Ages 5 through 11 years of age: 7 visits
  - Ages 12 through 17 years of age: 6 visits
  - Ages 18 to 21st birthday: 2 visits
- Lab tests ordered at the well-child visits and performed in the office or in the laboratory
- Well child care immunizations as listed:
  - DPT (diphtheria, pertussis and tetanus)
  - Polio
  - MMR (measles, mumps and rubella)
  - Varicella (chicken pox)
  - Hepatitis B
  - Hemophilus
  - Tetanus-diphtheria
  - Pneumococcal
  - Meningococcal Tetramune
  - Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in the state where your child lives

After coverage under this Plan stops, there are no extended benefits.

These preventive care services are not covered:

- Screening tests done at your place of work at no cost to you
- Free screening services offered by a government health department
- Tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests

Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.

Additional information can be found:
http://www.healthcare.gov/center/regulations/prevention.html;
http://www.ahrq.gov/clinic/uspstfix.htm; or
http://www.cdc.gov/vaccines/recs/acip/.

Private Duty Nursing Care

Private duty nursing care given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.).

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- Artificial arms, legs, feet and hands
- Artificial face, eyes, ears and nose
- Wigs for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury, unlimited
- Breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see Durable Medical Equipment (DME) in this section.

Psychologist Services

See the Mental Health Benefits section.

Radiation Therapy

Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes.

Rehabilitation Therapy

Inpatient

Services of a Rehabilitation Facility for room, board, care and treatment during a confinement.

Inpatient rehabilitative therapy is a Covered Health Service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

Covered Health Services are limited to a combined total of 120 days of confinement in a Rehabilitation Facility each calendar year, combined In-Network and Out-of-Network.

Please note that, in general, the intent of rehabilitation therapy is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The Covered Person is expected to improve to a predictable level of recovery.

Benefits are available when rehabilitation services are needed on a daily basis. Accordingly, Benefits are not available when these services are required intermittently (such as physical therapy three times a week).

Benefits are not available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting

personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. (Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)

Outpatient

Services of a Hospital or Comprehensive Outpatient Rehabilitative Facility (CORF).

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.

The Plan gives the Claims Administrator the right to exclude from coverage rehabilitation services that are not expected to result in significant physical improvement in your condition within two months of the start of treatment. In addition, the Claims Administrator has the right to deny Benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Covered Health Services are limited to 30 days of therapy each calendar year. Additional visits may be available if necessary. A day of therapy includes all services given by or visits to the Hospital or CORF in any one day.

Covered Health Services for each day of therapy reduces the number of visits under Covered Health Services for Outpatient Physical Therapy, Outpatient Occupational Therapy or Speech Therapy. This reduction only applies to days of therapy during which the therapy includes services given by a physical therapist, occupational therapist or speech therapist.

Skilled Nursing Facility Services

- Room and Board
- Covered Expenses for Room and Board are limited to the facility's regular daily charge for a semi-private room

Covered Health Services are limited to a combined total of 120 calendar days of confinement in a Skilled Nursing Facility each calendar year, combined In-Network and Out-of-Network. Non-skilled respite care is not covered.

Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The Covered Person is expected to improve to a predictable level of recovery.

Benefits are available when skilled nursing services are needed on a daily basis. Accordingly, Benefits are not available when these services are required intermittently (such as physical therapy three times a week).

Benefits are not available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. (Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but

is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)

Speech Therapy

Services of a licensed speech therapist.

These services must be given to restore speech lost or impaired due to one of the following:

- Surgery, radiation therapy or other treatment which affects the vocal chords
- Cerebral thrombosis (cerebral vascular accident)
- Brain damage due to accidental injury or organic brain lesion (aphasia)
- Accidental injury

Covered Health Services are limited to 30 visits each calendar year (In-Network and Out-of-Network combined). If Personal Health Support determines that additional visits are needed, they will be considered Covered Health Services.

Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, autism spectrum disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Covered Health Services are limited to 30 visits each calendar year (In-Network and Out-of-Network combined). If Personal Health Support determines that additional visits are needed, they will be considered Covered Health Services. Services may be provided for more than 30 visits if the Claims Administrator, after review of the participant's medical condition, determines that additional visits are necessary and medically appropriate.

Spinal Manipulations

Services of a Physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

Covered Health Services are limited to 30 visits each calendar year (In-Network and Out-of-Network combined).

Please note that the Plan excludes any type of therapy, service or supply including, but not limited to, spinal manipulations by a chiropractor or other doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.

Surgery

Services for surgical procedures.

Reconstructive Surgery

Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:

- Birth defect
- Sickness
- Surgery to treat a Sickness or accidental injury
- Accidental injury
- Reconstructive breast surgery following a necessary mastectomy
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental injury

Assistant Surgeon Services

Covered Expenses for assistant surgeon services are limited to 1/5 of the amount of Covered Expenses for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are not covered.

Multiple Surgical Procedures

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

- Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session
- Covered Expenses for any subsequent procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session
- If the multiple surgical procedures are the same procedure performed bilaterally during the same operative session, both procedures will be considered primary. Covered Expenses for any subsequent procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session

Transgender Benefit

Covered Health Service for the following Transgender Reassignment Benefits:

- Psychotherapy for gender identity disorders
- Pre– and post-surgical hormone therapy
- Transgender Reassignment Surgery, subject to the following requirement:
- The surgery must be performed by qualified provider
- The treatment plan must conform to HBIGDA (Harry Benjamin International Gender Dysphoria Association) standards
- You or your physician should notify Personal Health Support prior to Transgender Reassignment surgery, and before the time a transgender pre-surgical evaluation is performed

Vision Examinations

The Plan pays Benefits up to 100% for vision screenings including refractive examination by a provider in the provider's office every calendar year.

UnitedHealth Premium Program

This program makes it easier for you to identify leading cardiac hospitals and physicians across three important specialty areas of medicine: cardiac, cancer and orthopedic care. The program can help you make informed choices and makes it easy for you to get information online or over the phone. UnitedHealth Premium physicians and hospitals are part of the UnitedHealthcare network. Go to the Physicians and Facilities section of myuhc.com or call the toll-free number on your I.D. card for additional information.

Experimental or Investigational Services

If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

What Is Not Covered

General Exclusions and Limitations

This Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

- Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Appendix: Important Definitions
- Services or supplies received before an employee or his or her dependent becomes covered under this Plan
- Alternative treatments including acupressure, aroma therapy, hypnotism, massage therapy, rolfing and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health
- Abdominoplastys
- Treatment of benign gynecomastia (abnormal breast enlargement in males) unless medically necessary
- Cosmetic Procedures. See the definition in Appendix: Important Definitions. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)
    - Skin abrasion procedures performed as a treatment for acne
    - Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Covered Health Services
- Chelation therapy, except to treat heavy metal poisoning
- Completion of claim forms, or missed appointments
- Custodial Care. This is care made up of services and supplies that meets one of the following conditions:

- Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment
- Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional
- Care that meets one of these conditions is custodial care regardless of any of the following:
  - Who recommends, provides or directs the care
  - Where the care is provided
  - Whether or not the patient or another caregiver can be or is being trained to care for him or herself

- Prescription Drugs for outpatient use that are filled by a prescription order or refill; self-injectable medications (this exclusion does not apply to medications which, due to their characteristics, as determined by the Claims Administrator, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting)
- Ecological or environmental medicine, diagnosis and/or treatment
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home
- Eye glasses, contact lenses and, eye refractions exams, unless required due to an accidental injury or cataract surgery
- Herbal medicine, holistic or homeopathic care, including drugs
- Services, supplies, medical care or treatment given by one of the following members of the employee's immediate family:
  - The employee's spouse or domestic partner
  - The child, brother, sister, parent or grandparent of either the employee or the employee's spouse
- Services and supplies that the Covered Person is not legally required to pay
- Liposuction
- Surgical correction or other treatment of malocclusion
- Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case are determined to be:
-
  - not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
  - subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
  - the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
- Membership costs for health clubs, weight loss clinics and similar programs

- Nutritional counseling
- Occupational injury or Sickness. An occupational injury or Sickness is an injury or Sickness which is covered under a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or Sickness includes any injury or Sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Health Services
- Services given by a pastoral counselor
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, dehumidifiers, humidifiers, saunas and hot tubs, beauty/barber service, guest service, devices and computers to assist in communication and speech, batteries and battery chargers, air purifiers and filters, home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools)
- Private duty nursing services while confined in a facility
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services, or supplies given in connection with or related to the surgery
- Health services for organ and tissue transplants except as identified under Organ/Tissue Transplants unless the Claims Administrator determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines
- Reversal of sterilization
- Sensitivity training, educational training therapy or treatment for an education requirement
- Charges made by a Hospital for confinement in a special area of the Hospital which provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below. If that type of facility is otherwise covered under this Plan, then benefits for that covered facility which is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital
    - Adult or child day care center
    - Ambulatory surgical center
    - Skilled nursing facility
    - Hospice
    - Birthing center
    - Halfway house
    - Treatment Center
    - Vocational rehabilitation center.
    - Any other area of a Hospital which renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
- Has not been actively involved in your medical care prior to ordering the service
- Is not actively involved in your medical care after the service is received
- This exclusion does not apply to mammography testing
- Stand-by services required by a Physician
- Dental care, except as identified in the Covered Health Services section
- Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances
- Preventive dental care

- Diagnosis or treatment of the teeth or gums. Examples include:
- Extraction (including wisdom teeth)
- Restoration and replacement of teeth
- Medical or surgical treatments of dental conditions, except as noted above
- Services to improve dental clinical outcomes
- Dental implants and braces
- Crowns
- Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia (This exclusion would not apply to Orthognathic Surgery Benefits)
- Treatment of congenitally missing (missing at birth), malpositioned, or supernumerary (extra) teeth, even if part of a Congenital Anomaly
- Telephone consultations
- Tobacco dependency, except as covered under the Pharmacy Plan
- Non-surgical treatment of obesity, including morbid obesity
- Surgical treatment of obesity excluding severe morbid obesity (with a BMI greater than 40)
- Special foods, food supplements, liquid diets, diet plans or any related products, except nutritional supplements prescribed for the treatment of PKU
- Enteral feedings and other nutritional and electrolyte formulas, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals, except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants, hair weaving or any drug if such drug is used in connection with baldness
- Services given by volunteers or persons who do not normally charge for their services
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded
- Services received from a personal trainer

Mental Health/Substance Abuse Exclusions Include:

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless pre-authorized by the Mental Health/Substance Abuse Administrator
- Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Administrator, are any of the following: (1) not consistent with generally accepted standards of medical practice for the treatment of such conditions; (2) not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; (3) typically do not result in outcomes demonstrably better than other available treatment

alternatives that are less intensive or more cost effective; (4) not consistent with the Mental Health/Substance Abuse Administrator's level of care guidelines or best practices as duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. The Mental Health/Substance Abuse Administrator my consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria

- Mental Health Services as treatments for V-code conditions as listed with the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical base
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the MH/SUD Administrator
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*
- Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- Mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction
- Substance Abuse Services for the treatment of nicotine or caffeine use
- Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders
- Routine use of psychological testing without specific authorization
- Pastoral counseling.

How to Obtain Benefits

For medical coverage, all you need do is show your I.D. Card to your provider. You need not complete a claim form for In-Network services provided under the UnitedHealthcare Choice Plus Plan. However, you may be required to sign that services were performed. Claim forms may be required for Out-of-Network services.

How to File a Claim

This section provides you with information about how and when to file a claim.

- If you receive Covered Health Services from an In-Network provider, you do not have to file a claim. The Claims Administrator pays these providers directly. If an In-Network provider bills you for any Covered Health Service, contact the Claims Administrator. You are responsible for Copayments/Coinsurance to an In-Network provider at the time of service or when you receive a bill from the provider.

- If you receive Covered Health Services from an Out-of-Network provider, you are responsible for filing a claim. Claims must be filed within 18 months of the date of service.

Filing a Claim for Benefits

When you receive Covered Health Services from an Out-of-Network provider as a result of an Emergency or if you are referred to an Out-of-Network provider, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described below.

You must submit a request for payment of Benefits within 18 months after the date of service. If you don't provide this information to us within 18 months of the date of service, Benefits for that health service will be denied or reduced, in our or the Claim Administrator's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

If an Employee provides written authorization to allow direct payment to a provider, all or a portion of any Covered Expenses due to a provider may be paid directly to the provider instead of being paid to the Employee. We will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Employee's name and address
- The patient's name and age
- The number stated on your I.D. card
- The name and address of the provider of the service(s)
- A diagnosis from the Physician
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge
- The date the Injury or Sickness began
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s)

Payment of Benefits

Through the Claim Administrator, a Benefit determination will be made as set forth below. Benefits will be paid to you unless either of the following is true:

- The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider
- You make a written request to be paid directly at the time you submit your claim

The Claims Administrator will notify you if additional information is needed to process the claim. The Claims Administrator will pend your claim until all information is received.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 calendar days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 calendar days and pend your claim until all information is received.

Once notified of the extension you then have 45 calendar days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 calendar days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 calendar days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 calendar days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 calendar days after the claim was received, and may request a one-time extension not longer than 15 calendar days and pend your claim until all information is received. Once notified of the extension you then have 45 calendar days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 calendar days after the information is received. If you don't provide the needed information within the 45 calendar day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72-hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition
- Notice of denial may be oral with a written or electronic confirmation to follow within three calendar days
- If you filed an urgent care claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information

You will be notified of a determination no later than 48 hours after the Claim Administrator's receipt of the requested information or the end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Questions and Appeals

This section provides you with information to help you with the following:

- Questions or concerns about Covered Health Services or your Benefits
- How to appeal if you are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in (How to File a Claim) you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

If you are appealing an Urgent Care Claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your I.D. card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the I.D. card
- The date(s) of medical service(s)
- The provider's name
- The reason you believe the claim should be paid

- Any documentation or other written information to support your request for claim payment

Your first appeal request must be submitted to the Claims Administrator within 180 calendar days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of pre-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 calendar days of receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 calendar days from receipt of a request for review of the first level appeal decision
- For appeals of post-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 calendar days of receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 calendar days from receipt of a request for review of the first level appeal decision

For procedures associated with urgent claims, see "Urgent Claim Appeals That Require Immediate Action."

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 calendar days from receipt of first level appeal decision.

For pre-service and post-service claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding. Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is medically necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the

determination taking into account the seriousness of your condition. For urgent claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claim Administrator's decisions are conclusive and binding.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services; or
- as otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if Claims administrator fails to respond to your appeal within the time lines stated below.

You may request an independent review of the adverse benefit determination. Neither you nor Claims administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You, your treating Physician or an authorized designated representative may request an independent review by contacting the toll-free number on your I.D. card or by sending a written request to the address on your I.D. card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by Claims administrator and has no material affiliation or interest with Claims administrator or your employer. Claims administrator will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of Claims administrator's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by Claims administrator in making a decision on the case; and
- all other information or evidence that you or your Physician has already submitted to Claims administrator.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and Claims administrator will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process

will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and Claims administrator with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact Claims administrator at the toll-free number on your I.D. card for more information regarding your external appeal rights and the independent review process.

How to Locate Providers

The UnitedHealthcare Choice Plus provider directory can be accessed online, without charge, at http:/www.myuhc.com/ (if you are enrolled in the Plan and have obtained a password) or at www.myuhc.com/groups/deloitte2.

You may also call the toll-free telephone number on your I.D. Card for assistance in locating a provider. Search for providers in the "Choice Plus" plan.

Circumstances that May Affect Your Benefits

When Coverage Ends

Your coverage will end on the last day of the month following your termination of employment or cessation of service to the Deloitte U.S. Firms if you are a partner or principal, or loss of eligibility for benefits.

If You Terminate Employment or Cease Providing Service to the Deloitte U.S. Firms

If you terminate your employment with the Deloitte U.S. Firms or cease providing service to the Deloitte U.S. Firms if you are a partner or principal, for any reason except retirement, disability or leave of absence, your coverage under this Medical Program will end. Medical coverage for you and your covered dependents may be continued under COBRA continuation provisions.

If You are on Leave, Salary Continuation or Sabbatical

If you take a leave of absence or are placed on salary continuation, or if your service is substantially interrupted for any other reason, your status as a Plan participant may be affected. If you take an approved leave of absence, your coverage may be continued for the duration of the approved leave for up to 12 months, provided you pay the full premium. However, if you are on a paid or unpaid parental leave, a paid or unpaid medical leave, or salary continuation, you are only required to pay the employee portion of the premium. Once you reach 12 months of leave, or if you cease to be an

employee prior to that time, your participation under the Plan will end and your coverage may be continued under COBRA Continuation Provisions.

If you are on a sabbatical, you will pay only the employee portion of the premium. If you are on a one-month sabbatical, you will pay in a lump sum from your paycheck upon your return to work. If you are on a three- to six-month sabbatical, premiums will be deducted from your paycheck during the sabbatical. If your pay during sabbatical is insufficient to cover benefit deductions, you will be direct billed.

If You Are on a Qualified Family and Medical Leave

If you are on a qualified family and medical leave, the Medical Program will continue to cover you for as long as you are considered an employee and are on a qualified family and medical leave. You must pay your regular contributions for this coverage for up to the 12 weeks of the qualified family and medical leave. After that, if you do not return from leave and are not disabled, the previous paragraph entitled "If You Are on Leave, Salary Continuation or Sabbatical" will apply.

If You Are on Military Leave

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), employees who serve in the Armed Forces of the United States, including reservists, who request a military leave have the right to elect continued health insurance coverage for themselves and their eligible dependents for a period of up to 24 months. For periods of up to 30 days of training or service, the employer can require the person to pay only the normal employee share, if any, of the cost of such coverage. For longer tours, the employer is permitted to charge the person up to 102 percent of the entire premium.

Under the military policy of the Deloitte U.S. Firms, employees who serve in the Armed Forces of the United States, including reservists, who request a military leave will have medical benefits coverage automatically continue for the duration of the leave that is a paid leave, and continue to pay for the employee portion of the cost of coverage through payroll deductions. Paid leave will last not less than six months. At such time that the leave becomes an unpaid leave, COBRA coverage will be offered for the period of 18 months. Service members may discontinue any or all of the coverage, and may re-enroll when employment is reinstated, generally without any waiting period or exclusion, except for service connected illnesses or injuries. Benefits are coordinated with coverage available through the government. Contact the CallCenter for assistance. You should also notify the CallCenter as soon as possible if there is a possibility you will seek a leave of absence under USERRA.

If You Become Disabled

If you are an employee and become totally and continuously disabled, you may elect to continue coverage under the Plan. You must continue to pay your regular contributions for this coverage for the first 12 months of the disability. If you cease to be an employee, coverage may be continued under COBRA Continuation Provisions.

If You Die

If you die while covered by the Plan, your eligible family members may elect to continue coverage through COBRA. If your dependents do not elect to continue coverage through COBRA, their coverage will terminate at the end of the month in which you die. Contact the CallCenter for details.

If Your Dependent Becomes Ineligible

If a member of your family becomes ineligible for coverage, he or she will have the option of continuing coverage under COBRA Continuation Provisions.

If You or Any Eligible Dependent Have Other Health Insurance

If you have hospital, surgical, or medical protection through a group plan in addition to this Medical Program, your coverage under this Program will be coordinated with your other coverage.

Coordination of Benefits

Your Medical Program is coordinated with other plans to which you or your covered dependents belong. This provision is designed to prevent duplication of payments when you or a dependent can collect benefits from another plan. This means that total benefits payable for an individual may not exceed the amount of eligible expenses you have actually incurred.

The following types of plans are coordinated with the Medical Program:

- Governmental benefit programs provided or required by law (other than Medicaid), or coverage under any law or plan, when by law the benefits under that coverage are in addition to those of any private insurance or other nongovernmental program
- No Fault automobile insurance plans
- Other group health care plans to which you or your covered dependents belong, whether insured or uninsured, prepayment, group practice, or individual practice coverage, but not including school accident coverage for students in grammar, high school, or college

The coordination of benefits provision does not apply to individual or private insurance plans.

Briefly, here's how benefits are coordinated when a claim is made:

- The primary plan pays its benefits first, without regard to any other plan
- The secondary plans then adjust their benefits so that the total benefits paid will not be greater than the amount of eligible expenses you actually incurred

A plan without a coordination provision is always the primary plan. If all plans have a coordination provision, here's how it works:

- The plan covering the patient directly, rather than as a dependent, will be the primary plan
- A plan covering a person as a laid-off or retired employee (or as his or her dependent) will be secondary to a plan that covers the person (or his or her dependent) who is not retired

If the person is also a Medicare beneficiary, the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if both of the following are true:

- Medicare is secondary to the plan covering the person as a dependent
- Medicare is primary to the plan covering the person as other than a dependent (example, a retired employee)

If a child is covered under both parents' plans and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year is the primary plan. If both parents have the same birthday, the plan that has covered a parent longer is the primary plan. However, if the other plan does not have this "birthday" rule, and as a result the plans do not agree on the order of benefits, the other plan's rule will determine which plan is primary.

If a child is covered under both parents' plans, and the parents are separated or divorced, the plans pay in this order:

- If the court has established one parent as financially responsible for the child's health care, the plan of the parent with that responsibility is primary, and the insurance company must be informed of the court decree
- The plan of the parent with custody of the child
- The plan of the spouse/domestic partner of the parent with custody of the child
- The plan of the parent who does not have custody of the child
- If none of the rules above apply, the plan that has covered the patient longer is primary

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.

The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same rule applies if a person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber for the longer period are determined before those of the plan which covered that person for the shorter period.

The Medical Program will pay the benefits described in this document when it is the primary plan. When it is the secondary plan, it will pay the difference between benefits paid from the primary plan and the amount of the eligible expenses you actually incurred up to the dollar amount it would have paid had it been the primary plan.

Right to Exchange Information

In order to coordinate benefit payments, the Claims Administrator needs certain information. It may get needed facts from or give them to any other organization or person. The Claims Administrator need not tell, nor get the consent of, any person to do this.

A Covered Person must give the Claims Administrator the information it asks for about other plans. If the Covered Person cannot furnish all the information the Claims Administrator needs, the Claims Administrator has the right to get this information from any source. If any other organization or person needs information to apply its coordination provision, the Claims Administrator has the right to give that organization or person such information. Information can be given or obtained without the consent of any person to do this.

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Claims Administrator may pay the Plan or organization or person for the amount of benefits that the Claims Administrator determines it should have paid. That amount will be treated as if it was paid under this Plan. The Employer or Plan will not have to pay that amount again.

Right of Recovery

If the amount of the payments the Claims Administrator made is more than the Claims Administrator should have paid under this COB provision, the Claims Administrator may recover the excess from one or more of the persons the carrier has paid or for whom the carrier has paid; or any other person or organization that may be responsible for the Benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

If You Become Medicare Eligible While You Are Actively Employed

If you become Medicare eligible and your employment status does not change, you and your covered dependents will continue to be covered by the Plan as your primary payor of health care benefits. You will continue to pay your regular contribution for this coverage.

If you wish, you may withdraw from the Plan when you become Medicare eligible and select Medicare as your primary payor of health care benefits.

If you choose Medicare and withdraw from the Plan, you and your dependents will not be covered at all by the Plan. For example, if you choose Medicare and are hospitalized, only Medicare will pay the hospital bill for all inpatient services. Contact the CallCenter if you want to make this change.

If you do enroll in Medicare and remain enrolled in the Plan, Medicare will be considered a secondary payer of benefits. Medicare may supplement the payments you receive from the Plan. However, these supplementary benefits will be limited to the amount Medicare would have paid in the absence of a group health plan and will only be paid to you to the extent that these amounts exceed the amount of benefits paid by the Plan.

If Your Spouse/Domestic Partner Becomes Medicare Eligible While You Are Actively Employed

If your covered spouse/domestic partner becomes Medicare eligible while you are actively employed, your spouse/domestic partner will continue to be covered by the Plan. If your spouse/domestic partner wishes, he or she may withdraw from the Plan at the time they become eligible for Medicare and select Medicare as his or her payer of health care benefits. Please contact the CallCenter if your spouse/domestic partner wishes to make this change.

When You Retire

If you are eligible to receive a retirement benefit under one of the Deloitte U.S. Firms' retirement plans, you and your covered dependents will continue to receive medical coverage similar to an active partner/principal or employee under the Medical Plan you have selected until you reach age 65, provided you pay the full amount of the premium. The cost of your medical coverage at retirement may be different from the amount you pay as an active partner/principal or employee. For more information, contact the CallCenter.

It's very important for you to enroll in Medicare at your earliest eligibility enrollment date. Once you reach age 65, Medicare automatically becomes the primary payor for your eligible medical expenses.

When you retire on or after age 65 or turn age 65 following early retirement, your medical coverage will automatically change to Medicare Carve Out coverage under the UnitedHealthcare Indemnity Plan, which supplements Medicare. This means that your Medicare Carve Out coverage will only cover those expenses not covered under Medicare. For this reason, it's very important for you to enroll in Medicare at your earliest eligibility enrollment date.

Other Events Ending Your Coverage

If any of the following events happen, the Claims Administrator will provide written notice to you that coverage has ended on the date the Plan Administrator identifies in the notice.

- Fraud or misrepresentation, or because you knowingly gave us or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. The Plan has the right to seek reimbursement of amounts paid to you during the time the fraud or misrepresentation occurred.
- A material violation of the terms of the Plan
- You permitted an unauthorized person to use your ID card, or you used another person's card
- You failed to pay a required contribution

You committed acts of physical or verbal abuse that pose a threat to our staff, the Claim Administrator's staff, a provider, or other Covered Persons.

Effective January 1, 2011, the Plan may not rescind coverage of any Participant unless the Participant commits fraud or makes an intentional misrepresentation of material fact prohibited by the Plan. The Plan will provide written notice to the Participant 30 days in advance of such rescission

COBRA Benefits/Continuation of Benefits Provisions

Introduction

In certain legally required situations you may request continuation of your coverage under the COBRA Continuation Provisions if your coverage would otherwise end. On April 7, 1986 a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the Plan would otherwise end. The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Both you and your domestic partner/spouse should take time to read this carefully. Nothing in this Summary Plan Description is intended to expand your rights beyond COBRA’s requirements.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary”. Partners/principals or employees, their spouses/domestic partners, and

their eligible dependents could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. If you are required to pay for COBRA continuation coverage, you will be notified at the time you are offered COBRA continuation coverage of the amount and date payment is due.

Entitlement to Elect COBRA Continuation Coverage

If you are a partner/principal or employee of the Deloitte US Firms, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced
- Your employment ends for any reason other than gross misconduct

If you are the spouse/domestic partner of a partner/principal/employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- The covered partner/principal/employee dies
- The covered partner/principal/employee's hours of employment are reduced
- The covered partner/principal/employee's employment ends for any reason other than his or her gross misconduct
- The covered partner/principal/employee becomes entitled to Medicare benefits (under Part A or Part B or both)
- You become divorced or legally separated from the covered partner/principal/employee or your domestic partnership is severed

If your spouse/domestic partner has retired from Deloitte and is entitled to participate in the Deloitte retiree medical plans, you will be eligible to continue retiree benefits as a surviving spouse if your spouse/domestic partner dies, though you will also be offered COBRA continuation coverage at that time. Eligibility for benefits will end and COBRA continuation coverage will be offered if the surviving spouse or domestic partner remarries or enters another domestic partnership after the retiree's death.

If you are an eligible dependent of a partner/principal/employee, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events happens:

- The partner/principal/employee dies
- The partner/principal/employee's hours of employment are reduced
- The partner/principal/employee's employment ends for any reason other than his/her gross misconduct
- The partner/principal/employee becomes entitled to Medicare benefits (under Part A, or Part B, , or both)
- The partner/principal/employee becomes divorced or legally separated; or their domestic partnership is severed
- The dependent stops being eligible for coverage under the Plan as a dependent

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Deloitte US Firms, and

that bankruptcy results in the loss of coverage of any retired partner/principal/employee covered under the Plan, the retired partner/principal/employee is a qualified beneficiary with respect to the bankruptcy. The retired partner/principal/employee's spouse/domestic partner, surviving spouse/domestic partner, and other dependents will also be qualified beneficiaries, if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the partner/principal/employee, commencement of a proceeding in bankruptcy with respect to the Deloitte US Firms or the partner/principal/employee's becoming entitled to Medicare benefits (under Part A, Part B,, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the partner/principal/employee and spouse/domestic partner or a dependent losing eligibility for coverage as a dependent), you must notify the Plan Administrator within 60 calendar days after the qualifying event occurs. The Plan requires you to complete a Life Event Form which you can obtain by contacting the CallCenter at +1 800 DELOITTE (+1 800 335 6488). You are required to return the form within 60 calendar days to:

PSN – CallCenter
Deloitte Services LP
4022 Sells Drive
Hermitage, Tennessee 37076
+ 1 800 DELOITTE (+1 800 335 6488)

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered partners/principals/employees may elect COBRA continuation coverage on behalf of their spouses/domestic partners and parents may elect COBRA continuation coverage on behalf of their children.

ELECTING COBRA Coverage

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA Election Notice and submit it to the COBRA Administrator (ADP). An Election Notice will be provided to qualified beneficiaries at the time of the qualifying event. You may also obtain a copy of the Election Form from the COBRA Administrator (ADP). Under federal law, you must have 60 days after the date of the COBRA Election Notice provided to you at the time of your qualifying event to decide whether you want to elect COBRA under the Plan.

Mail the Election Form to:

COBRA Administrator
ADP Benefit Services
P.O. Box 27478
Salt Lake City, UT 84127

+1 800 522 6621

If you do not choose COBRA continuation coverage, your group health coverage will end. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered partners/principals/employees may elect COBRA continuation coverage on behalf of their spouses/domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

If a qualified beneficiary has coverage under an HMO and relocates to an area not serviced by that HMO, he/she will be given the same coverage options available to active partners/principals/employee in the Plan who transfer to the area where the qualified beneficiary is relocating.

Qualified beneficiaries may be enrolled in one or more group health components of the Plan at the time of a qualifying event (medical, dental, voluntary visions, discount vision, the Healthcare Flexible Spending Account under the Plan). If a qualified beneficiary is entitled to a COBRA continuation coverage election as the result of the qualifying event, he or she may elect COBRA continuation coverage under any or all of the group health components of the Plan under which he or she was covered on the day before the qualifying event. (For example, if a qualified beneficiary was covered under the medical and dental components on the day before a qualifying event, he or she may elect COBRA continuation coverage under the dental component only, the medical component only, or under both the medical or dental. Such a qualified beneficiary could not elect COBRA continuation coverage under the Healthcare Flexible Spending Account under the Plan, because he or she was not covered under this component on the day before the qualifying event.

In considering whether to elect CORBA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of the COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

Length of COBRA Continuation Coverage

COBRA continuation coverage is temporary continuation of healthcare coverage. When the qualifying event is the death of the partner/principal/employee, the partner/principal/employee becoming entitled to Medicare benefits (under Part A, Part B, Part D or all), the partner/principal/employee's divorce or legal separation, or a dependent losing eligibility as a dependent, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the partner/principal/employee's hours of employment, and the partner/principal/employee became entitled to Medicare benefits less

than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the partner/principal/employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered partner/principal/employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his spouse/domestic partner and other dependents can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the partner/principal/employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan in a timely fashion, you and your entire family may be entitled to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The plan can charge qualified beneficiaries an increased premium, up to 150 percent of the cost of coverage, during the 11 month disability extension.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and last at least until the end of the 18 month period of COBRA continuation coverage. You must make sure that the COBRA Administrator (ADP) is notified no later than 60 calendar days after the latest of the following:

- The date of the SSA's disability determination
- The date of the covered partner/principal/employee's termination of employment or reduction of hours
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered partner/principal/employee's termination of employment or reduction of hours

You must also provide this notice within 18 months after the covered partner/principal/employee's termination of employment or reduction of hours in order to be entitled to a disability extension. The Plan requires you to complete the "Notification to ADP of a Disability COBRA Event" form which you can obtain from the COBRA Administrator (ADP). You are required to return the form to the COBRA Administrator (ADP) at the address listed on the form.

If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 calendar days of SSA's determination

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse/domestic partner and other dependents in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse/domestic partner and other dependents receiving continuation coverage if the partner/principal/employee or former partner/principal/employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or severs a domestic partnership, or if the dependent stops being eligible under the Plan as a dependent, but only if the event would have caused the spouse/domestic partner or dependent to lose coverage under the Plan had the first qualifying event had not occurred.

In all of these cases, you must make sure that the COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. The Plan requires you to complete the "Notification to ADP of a Second COBRA Event" form which you can obtain from The COBRA Administrator (ADP). You are required to return the form within 60 days after the qualifying event occurs to Deloitte COBRA (ADP) at the address listed on the form.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Plan Contact Information

COBRA Administrator
ADP Benefit Services
P.O. Box 27478
Salt Lake City, UT 84127
+1 800 522 6621

Termination of COBRA Continuation Coverage

COBRA continuation coverage will be terminated before the end of the 18, 29 or 36 month COBRA continuation coverage period if:

- Any required premium is not paid on time
- A qualified beneficiary becomes covered under another group plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary after electing continuation coverage
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage
- The employer ceases to provide any group health plan for its partners/principals/employees and retirees
- If coverage has been extended for up to 29 months due to disability, and the qualified beneficiary is subsequently determined no longer to be disabled

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

At the end of the 18 month, 29 month, or 36 month continuation coverage period, you are allowed to enroll in an individual conversion health plan provided under your current plan you are enrolled in at the end of the continuation coverage period.

Cost of COBRA Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and partner/principal/employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. The required payment for each group health component of the Plan under which you are entitled to elect COBRA continuation coverage will be described to you in the COBRA Election Notice.

Payment for COBRA Continuation Coverage

First payment for COBRA Continuation Coverage

If you elect COBRA continuation coverage, you do not have to send any payment with the Election Form. The COBRA Administrator (ADP) will bill you for the applicable COBRA continuation coverage premium. You must make your first premium payment for COBRA continuation coverage not later than 45 calendar days after the date of your election. (This is the date the Election Notice is post-marked.) If you make your first payment for COBRA continuation coverage in full later than 45 calendar days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan.

Periodic payments for COBRA Continuation Coverage

After you make your first payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary will be described to you in the COBRA Election Notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for COBRA continuation coverage is due on the first day of each month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send you bills in the form of COBRA Premium Coupons mailed monthly about the fifth of the month for the next month's payment. All of these premiums must be postmarked on or before 30 days after the due date. The due date is the first day of the period of coverage. For example, the premium for the month of April is due no later than May 1.

COBRA does not require bills to be sent. Although the COBRA Administrator (ADP) will send you a bill in the form of a premium coupon, it is your responsibility to remit full payment within the proper time period even if you do not receive a bill. No late or reminder notice will be sent for payments that have not been made.

All payments, including your initial payment, must be in the form of a check, cashier's check, or money order, and made payable to ADP.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 calendar days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day

of the coverage period) when the periodic payment is received. This means that any claim that you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If payment is postmarked one or more days after the end of the grace period, it will not be accepted and coverage will be terminated retroactive to the last period paid in full in a timely manner. Once coverage is terminated it cannot be reinstated.

Significant partial payment is not payment in full and will be returned. Payment must be made in full in the allotted grace period or coverage will be terminated retroactively to the last period paid in full in a timely manner.

Payments received that are returned by the bank for insufficient funds will result in return check charges in addition to termination of coverage if a replacement payment in the form of a cashier's check, certified check or a money order is not made within the grace period.

Payments should be mailed to the address indicated on the premium coupon. Contact the COBRA Administrator (ADP) if a premium coupon is not received.

Your first payment and all periodic payments for COBRA continuation coverage should be sent to:

COBRA Administrator
ADP Benefit Services
P.O. Box 27478
Salt Lake City, UT 84127

More Information about Individuals Who May Be Qualified Beneficiaries

Alternate recipients under QMCSOs

A child of the covered participant who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Deloitte U.S. Firms during the covered participant's period of employment with the Deloitte U.S. Firms is entitled to the same rights to elect COBRA continuation coverage as an eligible dependent child of the covered participant.

Additional Information Regarding COBRA Continuation Coverage Converting to an Individual Policy

When coverage for you or your dependents ends, coverage under this Medical Program may be converted to coverage under an individual plan with the insurance company if you are ineligible for any other coverage.

Coverage under an individual policy is different from coverage under this Program. To convert coverage, you must complete an application form available from UnitedHealthcare. Application and payment for the first premium to the insurance company are due within 31 calendar days after coverage under this Medical program ends. The converted coverage will not provide the same benefits as the group plan. The rate you pay will be the premium charged for individual policies.

Conversion policies are designed to make individual coverage available to someone who may not otherwise be able to obtain insurance. You should be aware that there may be financial and other advantages to obtaining an individual policy outside of the conversion availability.

Medicare Part D (Medicare Prescription Coverage)

Important Notice from Deloitte LLP and its Subsidiaries about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage for the medical plan you are currently enrolled in under the Deloitte health plans and about your options under Medicare's prescription drug coverage.

This information can help you decide if you want to join a Medicare drug plan (Medicare Part D). If you are considering participation, you should compare your current Deloitte coverage, including which drugs are covered at what cost, with the coverage and costs of the Medicare prescription drug plan alternatives in your area. Information about where you can get help making decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Deloitte U.S. Firms have determined that the prescription drug coverage offered by the medical plan in which you are currently enrolled under the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is, therefore, considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) during which you may join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you do decide to join a Medicare drug plan and drop your medical coverage under the Deloitte health plans, you may reenroll in your medical coverage under the Deloitte health plans only as a result of a life event, such as a change in marital status, change in dependent status, loss of other

coverage, etc., or during a subsequent Annual Open Enrollment period. Once Annual Open Enrollment is over for a given year, you can only make changes within 31 calendar days of a qualifying life event.

Because your prescription drug coverage under the Deloitte medical plan is integrated with your medical coverage, you cannot drop your prescription drug coverage without also dropping your medical coverage with Deloitte.

If you choose to enroll in a Medicare prescription drug plan and retain your medical coverage with Deloitte, you will still have both medical and prescription coverage under your Deloitte plan. However, as stated above, if you have medical coverage through the Deloitte U.S. Firms, you do not need to enroll in a Medicare prescription drug plan. While you still have the right to enroll in a Medicare prescription drug plan and pay the required premiums, you should research if you would receive any additional benefits from choosing this coverage in addition to your existing prescription drug coverage.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

If you drop or lose your coverage under a Deloitte health plan and do not join a Medicare drug plan within the 63 continuous day period after your Deloitte coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium under Medicare Part D may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium will be at least 19% higher than the Medicare base beneficiary prescription premium. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. Also, you should remember that Medicare Prescription Open Enrollment is only held from October 15 to December 7 each year, so if you go 63 continuous days or longer to enroll after dropping your Deloitte health coverage you may have to wait until October to join Medicare Part D.

For More Information about This Notice or Your Current Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call +1 800 MEDICARE (+1 800 633 4227). TTY users should call +1 877 486 2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at +1 800 772 1213 (TTY +1 800 325 0778). Please contact the CallCenter for further information at +1 800 DELOITTE (+1 800 335 6488)

NOTE: You will receive this notice each year you remain covered by the Deloitte U.S. Firms medical program. You will also receive it before the next period you may join a Medicare drug plan or if the coverage through the medical plan you are currently enrolled in through the Deloitte U.S. Firms' medical program changes. You also may request a copy of this notice at any time.

For More Information

If you have questions about your medical benefits, please contact the CallCenter at +1 800 DELOITTE (+1 800 335 6488). For non-urgent issues, you may also contact the CallCenter via web form on DeloitteNet at https://deloittenet.deloitte.com/WT/Tech/Support/Pages/APP_CCWF.aspx

Online Services

When you enroll in the UnitedHealthcare Choice Plus Plan, you are eligible to register on the myuhc.com website. When you register on that site, a password will be mailed to your home address within five business days. The https://www.myuhc.com/ site provides self-service web functions including:

- Verification of eligibility
- Check status of claims
- Review claims paid
- View provider directories
- Request I.D. cards
- Obtain healthcare and wellness information
- Live Nurse Chat
- Plan Comparison Calculator

Administrative Information

How the Coverage Is Provided

Your coverage under the UnitedHealthcare Choice Plus Plan is provided under an Administrative Services Agreement, No. 228222 between UnitedHealthcare Insurance Company and Deloitte LLP.

UnitedHealthcare is a named fiduciary of the Plan for purposes of denial and/or review of denied claims under the Plan. UnitedHealthcare's decision on any claim will be final.

All benefits becoming due under the Plan are funded by Deloitte LLP. Deloitte LLP has entered into an arrangement with UnitedHealthcare Insurance Company (called "UnitedHealthcare") that provides for UnitedHealthcare to process benefit claims and provide certain other services under the Plan. UnitedHealthcare Insurance Company does not insure the benefits described in this handbook.

Notice Required by the Florida Insurance Department

This Plan is a self-insured group health plan not regulated by the Florida Insurance Departments. Payment of claims is completely dependent upon the financial solvency of the employer or other entity sponsoring the Plan. No guaranty fund exists to cover claims a bankrupt or otherwise insolvent employer or plan sponsor cannot pay.

Modification or Termination of the Medical Program

The Deloitte U.S. Firms presently intend to continue the Plan. They do reserve the right, however, to change, modify, or even terminate the Program, in whole or in part, at any time at their sole discretion to the extent allowed by law.

Right of Recovery

The Claims Administrator may pay benefits that should be paid by another plan or organization or person. The Deloitte U.S. Firms or the Plan may recover the amount paid from the other plan or organization or person.

Benefits may be paid that are in excess of what should have been paid under this Plan. The Employer or Plan has the right to recover the excess payment.

Subrogation

The Plan has a right to subrogation and reimbursement, as defined below.

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity who caused the Sickness, Injury or damages;
- Sandia in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
    - underinsured or uninsured motorist insurance;
    - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
    - workers' compensation coverage; or
    - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
    - complying with the terms of this section;
    - providing any relevant information requested;
    - signing and/or delivering documents at its request;

  - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - responding to requests for information about any accident or injuries;
  - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
  - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- in case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Refer to Benefits on DeloitteNet for details of your medical coverage.

If you would like more information on WHCRA benefits, contact the CallCenter at +1 800 DELOITTE (+1 800 335 6488).

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Group health Plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity Act

The Mental Health Parity and Addiction Equity Act of 2008 amends ERISA and the Public Health Service Act to prohibit employers' health plans from imposing any caps or limitations on mental health treatment or substance use disorder benefits that aren't applied to medical or surgical benefits.

The Mental Health Parity and Addiction Equity Act does not require health insurance plans to provide mental health or substance use disorder benefits. However, for group health plans with 50 or more employees that choose to provide mental health and substance use disorder benefits, the Act does require parity with medical and surgical benefits.

Therefore, if the group health plan provides both medical/surgical benefits and also mental health and substance use disorder benefits it may not impose financial requirements and treatment limitations on those mental health and substance use disorder benefits

Summary Plan Description

required by the Employee Retirement Income Security Act of 1974 (ERISA). Additional copies may be obtained at no cost. Contact the CallCenter at +1 800 DELOITTE (+1 800 335 6488), or go to the Benefits section of DeloitteNet.

Name of Plan
Deloitte LLP Group Insurance Plan

Employer I.D. Number
13-5133500

Plan Number
505

Plan Sponsor
Deloitte LLP
1633 Broadway
New York, NY 10019-6708

+1 203 761 3000

Type of Plan
Welfare – Medical UnitedHealthcare Options PPO

Plan Year Ends
The Saturday nearest May 31st

Plan Administrator
Deloitte LLP
1633 Broadway
New York, NY 10019-6708

Type of Administration
Contract Administration – The above listed benefits are administered by UnitedHealthcare Options PPO

Agent for Service of Legal Process
Deloitte LLP
1633 Broadway
New York, NY 10019
c/o General Counsel
+1 212 489 1600

Service of legal process may also be made upon the Plan Administrator.

Loss of Benefits

You must continue to be a member of the class of employees to which the Plan pertains and continue to make the contributions agreed to when you enrolled, if any. Failure to meet any or all of these requirements may result in partial or total loss of your benefits. In addition, the Plan sponsor maintains the right to modify or terminate the Plan.

How to File a Claim

Claim forms may be obtained from the CallCenter at +1 800 DELOITTE (+1 800 335 6488) or on DeloitteNet.

The CallCenter is available to answer any questions concerning your insurance benefits and to assist you in filing claims.

The instructions on the claim form should be followed carefully. This will expedite the processing of your claim. Be sure all questions are answered fully.

When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

For additional information about filing claims, review of claim denial and claim appeals, refer to How to File a Claim.

Interpretation of Benefits

We and the Claims Administrator have sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan

- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments
- Make factual determinations related to the Plan and its Benefits

We and the Claims Administrator may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverage or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or the Claims Administrator may need additional information from you. You agree to furnish us and/or the Claims Administrator with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or the Claims Administrator with all information or copies of records relating to the services provided to you. We or the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Employee's enrollment form. We and the Claims Administrator agree that such information and records will be considered confidential.

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

The Plan protects the confidentiality of your personal and health information, including your medical records, claims and personal information. The Plan will not disclose your personal and health information without your consent, except as permitted by law.

A statement describing the Claims Administrator's policies and procedures for preserving this confidentiality of medical records is available and will be furnished to you upon request. To request a copy of this statement, call the Member Services Department phone number indicated on your Identification Card.

Refund of Overpayments

If the Claims Administrator pays Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person
- All or some of the payment the Claims Administrator made exceeded the Benefits under the Plan
- The refund equals the amount the Claims Administrator paid in excess of the amount the Claims Administrator should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future Benefits.

Limitation of Action

You cannot bring any legal action against us or the Claims Administrator to recover reimbursement until 90 calendar days after you have properly submitted a request for reimbursement as described in How to File a Claim. If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or the Claims Administrator.

You cannot bring any legal action against us or the Claims Administrator for any other reason unless you first complete all the steps in the complaint process. After completing that process, if you want to bring a legal action against us or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your complaint or you lose any rights to bring such an action against us or the Claims Administrator.

Notice of Privacy Practices

Effective April 14, 2003, updated February 17, 2011

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") the Group Insurance Plan maintained by Deloitte LLP and its subsidiaries (hereafter known as the "Deloitte U.S. Firms") is required to protect the personal health information of plan participants ("Protected Health Information"). The Deloitte LLP Group Insurance Plan (the "Plan") components covered by this Notice include the self-insured medical and dental plans as well as the Deloitte Flexible Spending Plan and the Voluntary Vision Care Program. If you participate in a fully insured health plan you will

receive a separate Notice of Privacy Practices from your insurance company, Health Maintenance Organization or other providers.

The Deloitte U.S. Firms have long understood and respected that medical information about you is personal, and we are committed to protecting the privacy of such information. The purpose of this Notice is to describe the health information practices of the Plan and its third party administrators, and to inform you about:

- The uses and disclosures of Protected Health Information by the Plan and its third party administrators
- Your individual rights with respect to the privacy of your Protected Health Information
- The Plan's duties with respect to your Protected Health Information
- Who to contact for further information about the Plan's privacy practices

Protected Health Information includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

How the Plan and Its Plan Administrators May Use and Disclose Protected Health Information

In order to administer the Plan, it may be necessary to use or disclose your Protected Health Information for a number of different reasons. This section will describe the different ways that your Protected Health Information may be used or disclosed. Other uses and disclosures not covered by this Notice or applicable law will be made only with your authorization.

Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations

The Plan will use Protected Health Information to carry out treatment, payment and health care operations.

Treatment. Your health providers may use your health information to facilitate your health treatment or services. Disclosure may be made to your health providers, including doctors, nurses, technicians, or hospital personnel who are involved in taking care of you. For example, the third party administrator may disclose the name of your primary care physician to a medical provider in order to obtain information relevant to your care.

Payment. Your personal health information may be disclosed to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from your health providers, or to coordinate your Plan coverage. For example, the Plan may review claims data to determine how much of a particular treatment should be paid.

Health Care Operations. The Plan may use and disclose health information about you for Plan operations. For example, your health information may be used in connection with quality assessment, underwriting, legal services, audit services, and general Plan administrative activities.

Disclosures of Protected Health Information will be made to the Plan Sponsor, c/o Deloitte Services LP, for purposes related to treatment, payment or health care operations. The Plan document has been amended as required by HIPAA.

Uses and Disclosures that are Required by Law

The Plan will disclose Protected Health Information to the extent that it is required by federal, state or local law. The following disclosures are required by law:

- Disclosure as required by any statutory law
- Disclosure to an authorized public health authority for public health activities, such as the prevention or control of disease, or to report reactions to medications or a problem with a health related product
- Disclosure to report abuse, neglect or domestic violence
- Disclosure to a health oversight agency necessary for health oversight activities, such as audits, investigations, or inspections in order to monitor health care systems and compliance with the law
- Disclosure for judicial and administrative proceedings expressly authorized by a court order, order from an administrative tribunal, a subpoena, discovery request, or other lawful process
- Disclosure to a law enforcement official for law enforcement and "whistleblower" purposes when required by law
- Disclosure regarding an individual who is or is suspected to be a victim of a crime
- Disclosure about a death to coroners, medical examiners, and funeral directors
- Disclosure for organ donation purposes
- Disclosures to avert a serious threat to health or safety of a person or the public
- Disclosure for specialized government functions, such as military or veteran purposes
- Disclosure for workers' compensation as required by law

Uses and Disclosures that Require Your Authorization

The Plan will not use or disclose your information for purposes other than those included in this Notice without your written authorization. Such use will only be for the time period and purposes stated in the authorization. You may revoke any such authorizations at any time, in writing.

Uses and Disclosures for Which You Must be Given an Opportunity to Agree or Disagree Prior to the Use or Disclosure

There may be emergency circumstances in which it may be necessary to disclose Protected Health Information about you to your family members or close personal friends. If you are available and not incapacitated, the disclosure will only be made if you have either agreed to the disclosure or have been given the opportunity to object and have not objected. If you are unavailable or otherwise incapacitated, the disclosure will only be made if it can be reasonably inferred from the circumstances that you do not object to the disclosure and that it is in your best interests that the disclosure be made.

Special Protections for Genetic Information

Notwithstanding the above, special protections are given to your genetic information. Deloitte is not permitted to disclose your genetic information for underwriting purposes, which includes:

- Determining whether you are eligible for benefits
- Determining the premium for coverage
- Determining whether you are subject to a pre-existing condition exclusion; and
- Other activities related to the creation, renewal or placement of the coverage provided by Deloitte
-
- Genetic information includes genetic tests of an individual or family member, family medical histories, and genetic services (e.g., counseling, education and evaluation of genetic

information). Family members include immediate family members and extended family members, up to the fourth degree of kinship.

Use of Minimum Necessary PHI

- Effective February 17, 2011, the Plan may use or disclose only the minimum necessary PHI to accomplish Plan functions. Whenever possible, the Plan will limit its use or disclosure of PHI to a "limited data set". A limited data set excludes many common identifying elements of PHI.

Your Rights Regarding Your Protected Health Information

Right to Inspect and Copy Protected Health Information

You have the right to inspect and copy your individual health information that may be used to make decisions about your Plan benefits. You must submit your request in writing. Note that you may be charged a fee for the costs of copying, mailing or other supplies associated with your request.

If your request is granted, the requested information will be provided within 30 calendar days if the information is maintained on site or within 60 days if the information is maintained off-site. A single 30 day extension is allowed as needed by the Plan.

If access is denied, you will be provided with a written denial letter setting forth the basis for the denial, a description of how you may have the denial decision reviewed and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Effective February 17, 2011, you have the right to access electronically an electronic health record that contains your Protected Health Information or to direct that a copy of the electronic health record be sent to a designated individual.

Right to Request Restrictions on the Uses and Disclosures of your Protected Health Information

You have the right to request a restriction or limitation on the health information that the Plan and its third party administrators use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information that is disclosed about you to someone who is involved in your health care or in the payment for your health care. For example, you could ask that information about a surgery not be disclosed. All such requests must be made in writing.

While the Plan is not required to approve requests for restrictions, the Plan will accommodate such requests if the request is reasonable and does not place an undue burden on the Plan.

The Plan will also accommodate reasonable requests to receive communications of Protected Health Information by alternative means or at alternative locations.

Also, effective as of February 17, 2011, Deloitte must agree to your request to restrict disclosure of Protected Health Information for payment or health care operations if you have paid the provider in full out-of-pocket. This restriction will not apply to disclosures of Protected Health Information for treatment purposes.

Right to Amend

If you feel that the health information maintained about you is incorrect or incomplete, you may ask to amend that information. You have the right to make this request for as long as the information is required to be maintained by or for the Plan. All such requests must be made in writing and must provide the reason for the request.

The Plan will respond to the request within 60 calendar days after receiving the request. The Plan may have a single 30-day extension, as needed. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your Protected Health Information.

Right to an Accounting of Disclosures

You have a right to request an accounting of disclosures by the Plan of your Protected Health Information. However, the Plan is not required to include the following types of disclosures in an accounting:

- Disclosures to carry out treatment, payment or health care operations
- Disclosures to you about your own Protected Health Information
- Disclosures made prior to April 14, 2003
- Disclosures pursuant to your written authorization

The accounting will be sent to you within 60 calendar days of your request. However, the Plan may have a single 30 day extension, as needed, if the Plan sends you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12 month period, the Plan may charge a reasonable fee for the cost of each subsequent accounting.

Right to Receive Notice of Any Breach of Unsecured PHI

Deloitte will be required to notify members of any breaches of unsecure PHI. Generally a breach is defined as unauthorized acquisition, access, use or disclosure of Protected Health Information which compromises the security or privacy of such information. Security and privacy are considered compromised when the disclosure poses a significant risk of financial, reputational or other harm to the member.

The notice of breach must be sent no later than 60 days from the date the breach was discovered. It must contain a description of the breach and types of unsecured Protected Health Information involved in the breach, protective measures the member should take, if any, to protect against losses and actions taken by Deloitte to investigate and mitigate any losses from the breach.

How to Exercise Your Rights under This Section

If you wish to exercise your rights under this Notice please contact the CallCenter at +1 800 DELOITTE (+1 800 335 6488). The CallCenter will either provide you with any required forms, or direct you to the appropriate Plan administrator, who may have access to your Protected Health Information.

Your Right to File a Complaint with the Plan or the Secretary of Health and Human Services

If you believe that your privacy rights have been violated you may file a complaint with the Privacy Officer at Deloitte Services LP, c/o National Benefits Group, 1633 Broadway, New York, NY 10019-6708.

You may file a complaint with the Secretary of U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Plan will not penalize you or retaliate against you for filing a complaint.

The Plan's Duties

We are required by law to provide you with this Notice, and to abide by the terms of this Notice as currently in effect. We reserve the right to revise the terms of this Notice. Any such changes will be effective for the health information in effect at the time of such change as well as for the health information that is received after the effective date of the amended Notice. This Notice will be posted on DeloitteNet.

Contact for More Information

If you have any questions regarding this Notice, you should contact the CallCenter at +1 800 DELOITTE (+1 800 335 6488).

Rights and Protections under ERISA

The following statement is required by federal law and regulation:

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

a) Examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration
b) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for the copies
c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report
d) Continue health care coverage for yourself, spouse/domestic partner or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage
e) Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights
f) Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement, or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Appendix: Important Definitions

These definitions apply when the following terms are used.

Ambulatory Surgical Center A specialized facility that is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located
- Where licensing is not required, it meets all of the following requirements:
- It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area
- It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure
- It provides at least one operating room and at least one post-anesthesia recovery room
- It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services
- It has trained personnel and necessary equipment to handle emergency situations
- It has immediate access to a blood bank or blood supplies
- It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room. It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary

An Ambulatory Surgical Center that is part of a Hospital, as defined herein, will be considered an Ambulatory Surgical Center for the purposes of this Plan.

Alternate Facility A health care facility that is not a Hospital or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility may provide services including pre-scheduled surgery and related services on an outpatient basis, as permitted by law.

Autism Spectrum Disorders – a group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

Birth Center A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located
- It meets all of the following requirements:
- It is operated and equipped in accordance with any applicable state law

- It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity
- It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders
- It is operated under the full-time supervision of a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.) or registered graduate nurse (R.N.)
- It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications
- It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary
- It is expected to discharge or transfer patients within 24 hours following delivery

A Birth Center which is part of a Hospital, as defined herein, will be considered a Birth Center for the purposes of this Plan.

Brand Name Drug A Prescription Drug which is (1) manufactured and marketed under a trademark or name by a specific drug manufacturer; and (2) identified as a Brand Name Drug by UnitedHealthcare.

Calendar Year A period of one year beginning with a January 1.

Cancer Resource Services The company's program made available by the employer to employees. The Cancer Resource Services Program provides information to employees or their covered dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

Claims Administrator UnitedHealthcare Insurance Company

Comprehensive Outpatient Rehabilitation Facility A facility which is primarily engaged in providing diagnostic, therapeutic and restorative services to outpatients for the rehabilitation of injured or sick persons and which fully meets one of the following two tests:

- It is approved by Medicare as a Comprehensive Outpatient Rehabilitation Facility
- It meets all of the following tests:
- It provides at least the following comprehensive outpatient rehabilitation services:
- Services of Physicians who are available at the facility on a full or part- time basis
- Physical therapy
- Social or psychological services
- It has policies established by a group of professional personnel (associated with the facility) including one or more Physicians to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full or part-time Physician
- It has a requirement that every patient must be under the care of a Physician
- It is established and operated in accordance with the applicable licensing and other laws

Congenital Heart Disease Resource Services The Claims Administrator's program made available by the Employer to Employees. The Congenital Heart Disease Resource Services program provides information to Employees or their Covered Dependents with congenital heart disease and offers access to additional centers for the treatment of congenital heart disease.

Cosmetic Procedures Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Personal Health Support on our behalf.

Covered Expense(s) Covered Expenses for Covered Health Services, incurred while the Plan is in effect, are determined as stated below.

- For Network Benefits, Covered Expenses are based on either of the following:
  - When Covered Health Services are received from Network providers, Covered Expenses are the contracted fee(s) with that provider
  - When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by the Claims Administrator, Covered Expenses are the fee(s) that are negotiated with the non-Network provider
- For Non-Network Benefits, Covered Expenses are determined by either:
  - Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors
  - Any of the following:
    - Selected data resources which, in the judgment of the Claims Administrator, represent competitive fees in that geographic area
    - Fee(s) that are negotiated by with the provider
    - Non-Network Reimbursement % of the billed charge
    - A fee schedule that the Claims Administrator develops

These provisions do not apply if you receive Covered Health Services from a non-Network provider in an Emergency. In that case, Covered Expenses are the amounts billed by the Provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Covered Expenses in the form of a Copayment.

Covered Expenses are subject to the Claim Administrator's reimbursement policy guidelines.

Covered Health Service(s) Those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in "What is Covered" as a Covered Health Service, which is not excluded under "What is Not Covered," including Experimental or Investigational Services and Unproven Services.

Covered Health Services must be provided:

- When the Plan is in effect
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Covered Family Members or Covered Person The employee and the employee's wife or husband, domestic partner and/or dependent children or adults who are covered under this Plan.

Dental Transplant Preparation Dental procedures necessary to prepare a patient for an organ transplant (the dentist would be reviewing any sources of infection in the mouth that could jeopardize the transplant procedure).

Designated Transplant Facility A facility designated by UnitedHealthcare to render necessary Covered Health Services for Qualified Procedures under this Plan.

Designated United Resource Network Facility A Hospital that the Claims Administrator names as a Designated United Resource Network Facility. A Designated United Resource Network Facility has entered into an agreement with the Claims Administrator to render Covered Health Services for the treatment of specified diseases or conditions. A Designated United Resource Network Facility may or may not be located within our geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated United Resource Network Facility.

Durable Medical Equipment Medical equipment that is all of the following:

- Can withstand repeated use
- Is not disposable
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms
- Is appropriate for use in the home

Emergency/ Emergency Care A serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance abuse which meets both of the following criteria:

Arises suddenly
In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Experimental, Investigational or Unproven Services Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination is made regarding coverage in a particular case are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use
- Subject to review and approval by any institutional review board for the proposed use
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed

The Company, in its judgment, may deem an Experimental, Investigational or Unproven Service covered under this Plan for treating a life threatening sickness or condition if it is determined by

the Company that the Experimental, Investigational or Unproven Service at the time of the determination met all of the following conditions:

- Is proved to be safe with promising efficacy
- Is provided in a clinically controlled research setting
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health

(For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment).

Generic Drug A Prescription Drug which is: (1) chemically equivalent to a Brand Name Drug whose patent has expired; and (2) identified as a Generic Drug by UnitedHealthcare.

Home Health Care Agency An agency or organization which provides a program of home health care and which meets one of the following three tests:

- It is approved under Medicare
- It is established and operated in accordance with the applicable licensing and other laws
- It meets all of the following tests:
- It has the primary purpose of providing a home health care delivery system bringing supportive services to the home
- It has a full-time administrator
- It maintains written records of services provided to the patient
- Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available
- Its employees are bonded and it maintains malpractice insurance

Hospice An agency that provides counseling and incidental medical services for a terminally ill individual. Room and Board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a Hospice
- It is licensed in accordance with any applicable state laws
- It meets the following criteria:
- It provides 24 hour-a-day, 7 day-a-week service
- It is under the direct supervision of a duly qualified Physician
- It has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients
- The main purpose of the agency is to provide Hospice services
- It has a full-time administrator
- It maintains written records of services given to the patient
- It maintains malpractice insurance coverage

A Hospice which is part of a Hospital will be considered a Hospice for the purposes of this Plan.

Hospital An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations

- It is approved by Medicare as a Hospital
- It meets all of the following tests:
- It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians
- It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses
- It is operated continuously with organized facilities for operative surgery on the premises
-
- Intensive Outpatient Treatment – a structured outpatient Mental Health or Substance Abuse treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week
-
- Intermediate Care – Mental Health or Substance Abuse treatment that encompasses the following:
-
- Care at Residential Treatment Facility;
- Care at a Partial Hospitalization/Day Treatment program; or
- Care through an Intensive Outpatient Treatment Program

Licensed Counselor A person who specializes in Mental Disorder Treatment and is licensed as a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Medicare The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

Mental Disorder Treatment Mental Disorder Treatment is treatment for both of the following:

- Any Sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/ or physiological dependence or addiction to alcohol or psychiatric drugs or medications, regardless of any underlying physical or organic cause
- Any Sickness where the treatment is primarily the use of psychotherapy or other psychotherapist methods

All inpatient services, including Room and Board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a Sickness identified in the DSM, are considered Mental Disorder Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the Sickness which is identified in the DSM is considered Mental Disorder Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered Mental Disorder Treatment.

Prescription Drugs are not considered Mental Disorder Treatment.

Neonatal Resource Services (NRS) A program administered by UnitedHealthcare or its affiliates made available to you by the Deloitte U.S. Firms. The NRS program provides guided access to a specialized network of NICU providers and nurse consulting services to help manage NICU admissions.

Network Pharmacy A pharmacy which has (1) entered into an agreement with UnitedHealthcare or its designee to provide Prescription Drugs to Covered Persons; (2) has agreed to accept specified reimbursement rates for dispensing Prescription Drugs and (3) has been designated by UnitedHealthcare as a Network Pharmacy. A Network Pharmacy can be either a retail or a mail service pharmacy.

Network Provider A provider which participates in the Network.

Nurse-Midwife A person who is licensed or certified to practice as a Nurse-Midwife and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse
- A person who has completed a program approved by the state for the preparation of Nurse-Midwives

Nurse Practitioner A person who is licensed or certified to practice as a Nurse-Practitioner and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse
- A person who has completed a program approved by the state for the preparation of Nurse Practitioners

Other Services and Supplies Services and supplies furnished to the individual and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

Out-of-Network Hospital A Hospital (as defined) that does not participate in the Network.

Out-of-Network Provider A provider which does not participate in the Network.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital based program and that provides services for at least 20 hours per week.

Physician A legally qualified:

- Doctor of Medicine (M.D.)
- Doctor of Chiropody (D.P.M.; D.S.C.)
- Doctor of Chiropractic (D.C.)
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Podiatry (D.P.M.)

Plan The employee's medical benefits described in the Medical Program UnitedHealthcare Preferred Provider Plan section of Benefits in Balance, available on DeloitteNet.

Pre-Admission Tests Tests performed on a Covered Person in a Hospital before confinement as a resident inpatient provided they meet all of the following requirements:

- The tests are related to the performance of scheduled surgery
- A Physician has ordered the tests after a condition requiring surgery has been diagnosed and Hospital admission for surgery has been requested by the Physician and confirmed by the Hospital

- The Covered Person is subsequently admitted to the Hospital, or the confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in the Covered Person's condition which precludes the surgery

Prescription Drugs A legend drug, medication, product or device which has been approved by the Federal Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of coverage under the Plan, this definition includes insulin and the following diabetic supplies: insulin syringes with needles; blood testing strips - glucose; urine testing strips - glucose; ketone testing strips and tablets; lancets and lancet devices.

Prescription Drug Cost UnitedHealthcare's contracted reimbursement rate, including any sales tax, with the Network Pharmacy where a Prescription Drug is dispensed. The Prescription Drug Cost does not include any manufacturer's refunds or incentive payments which may be received by and will be retained by the Claims Administrator.

Prescription Order or Refill The directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Psychologist A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required

Rehabilitation Facility A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Reproductive Resource Services (RRS) A program administered by UnitedHealthcare or its affiliates made available to you by Deloitte. The RRS program provides:

- A specialized clinical consulting services to Employees and enrolled Dependents to educate on infertility treatment options
- Access to specialized network facilities and Physicians for infertility services
-
- Residential Treatment Facility – a facility which provides a program of effective Mental Health Services or Substance Abuse Services treatment and which meets all of the following requirements:
-
- It is established and operated in accordance with applicable state law for residential treatment programs;
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Abuse Administrator;
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- It provides at least the following basic services in a 24-hour per day, structured milieu: room and board; evaluation and diagnosis; counseling; and referral and orientation to specialized community resources.
- A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Room and Board Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the Hospital as a condition of occupancy of the

class of accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.

Sickness The term "Sickness" used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

Skilled Nursing Facility If the facility is approved by Medicare as a Skilled Nursing Facility then it is covered by this Plan.

If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws
- It is under the supervision of a licensed Physician or registered graduate nurse (R.N.) who is devoting full time to supervision
- It is regularly engaged in providing Room and Board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or Sickness
- It maintains a daily medical record of each patient who is under the care of a licensed Physician
- It is authorized to administer medication to patients on the order of a licensed Physician
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill

A Skilled Nursing Facility which is part of a Hospital will be considered a Skilled Nursing Facility for the purposes of this Plan.

Specialist A Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Drugs Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled drugs that require close supervision and monitoring.

Transitional Care – Mental Health Services/Substance Abuse Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
Supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Treatment Center A facility that provides a program of effective Mental Disorder Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law
- It provides a program of treatment approved by a Physician and UnitedHealthcare

- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient
- It provides at least the following basic services:
- Room and Board (if this Plan provides inpatient benefits at a Treatment Center)
- Evaluation and diagnosis
- Counseling
- Referral and orientation to specialized community resources
- A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center

UnitedHealthcare UnitedHealthcare Insurance Company

Unproven Services Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.